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The Post-Operative Treatment of Mastoidectomy

By DR. DUMONT.

Before discussing the post-operative treatment of a patient who has undergone mastoidectomy, it may be appropriate to consider the operation that has been done and its purpose; and to recall to you the importance that must be paid to the anatomical landmarks in the surgery of the mastoid.

The operation has been done for acute mastoiditis, inflammation and infection, usually with pus formation, of the cells of the mastoid, lying just back of, and communicating with, the middle ear. You will recall that the mastoid portion of the temporal bone is notable for its cellular consistency and it is these that have become the focus of an infection. The mastoid antrum is the largest of these hollow spaces and it is directly in communication with the middle ear. It is most probable that infections of the middle ear and of the mastoid have had their origin in the nasopharynx. From thence the bacteria have travelled up the eustachian tube, infected the middle ear, and when the bodily resistance has been unable to curb the invader at this point, entrance has been made into the mastoid itself. That a blood-borne infection of the mastoid may occur at times cannot be denied, but the more usual process is an infection by direct extension.

The surgeon's purpose in entering the mastoid is to remove all the diseased tissues and to drain the infected area. The more thoroughly he does his work, the better the result. When it is remembered that just above the operative site he may break into the middle fossa of the skull and just below and posteriorly he may easily go into the large lateral sinus that is returning blood from the brain, it will be recognised that surgery of the mastoid is not to be done by unskilled hands. Even though the operator may do no injury to the brain or its vessels, he still runs the chance of damaging the facial nerve, or the ossicles of the middle ear or the semicircular canals, all of which structures lie within the reach of a carelessly directed curette.

There are two types of mastoid operations: the simple mastoidectomy, the post-operative care of which we are going to consider, and the radical operation. The radical operation, as the name suggests, is a radical procedure to relieve a chronic otitis media with any of the complications that may go with it. It converts the middle ear and the mastoid antrum into one cavity, does away with the small ossicles that join the drum to the internal ear, and closes off the eustachian tube. It is done only when all other methods have failed to cure a chronically discharging ear, or when complications demand its use.

In the simple operation the mastoid cells and the mastoid antrum are opened widely and all of the diseased tissue is curetted out. It is very necessary that a thorough job be done the first time, or one will find himself confronted with the unpleasant task of reoperation. A sterile gauze wick, either iodoform or plain, is placed so that one end remains in the antrum, the other end protruding from the lower angle of the wound. The tissues are brought together over this drain and the skin is closed entirely except

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at the lower end where the wick emerges. Where extensive damage has been done to the bone or where suppuration is abundant it may be necessary to leave the wound open and pack with iodoform gauze, allowing granulation tissue to form in the bottom as the pack is removed. However, this leaves extensive scarring and is not at all necessary for the usual case of simple mastoiditis. Another gauze wick is placed in the external auditory canal and a large sterile gauze bandage either dry or moistened with normal saline is placed over the wound and the ear. The dressing is held in place by a figure-of-eight bandage.

The general post-operative treatment of this patient is the same as that following any major surgical operation. He is placed in a warm bed; if need be, heat is applied to his extremities and everything is done to promote his comfort and to combat the shock that the operation has entailed. A careful temperature chart should be kept which, perhaps more than anything else, is a guide to the surgeon in post-operative management. For the first day the temperature may be quite high—even up to 104 degrees—but this should occasion no undue alarm. Children particularly are prone to such temperature increases; they have such sensitive organisms that a marked increase in temperature or pulse is not unusual and should not cause excessive worry. In very young children the fever may last for several days or even for a week. A fever persisting beyond this time may of course spell some complication, such as an infected trombus of the lateral sinus, erysipelas, or simply poor drainage. Pain after the operation should be relieved by codein—gr. "¼" to gr. "1" or morphine gr. ⅙ to ¼ as often as may be indicated. For the first few days a liquid diet should be given; preferably warm liquids, as iced drinks are liable to upset the very young patient. A mild laxative, such as milk of magnesia or fluid extract of cascara, should be ordered on the second day.

The pain in the region of the ear is naturally the most distressing of the post-operative symptoms, and one that calls for considerable ingenuity to alleviate. The careful nurse will be ready at all times to aid the patient in moving his head from one position to another, thereby materially reducing the pain that accompanies these movements. The head should be grasped firmly between the two hands and placed gently in the new position. A specially designed inflatable rubber cushion has been used by a number of surgeons in securing comfort after operation. This cushion is designed so that the head is comfortably supported and at the same time all pressure is removed from the operated area. This position, with operative wound downward, promotes drainage. You may visualise this cushion better by comparing it with the air cushion used so commonly in the treatment of bed sores; the principal difference being that the mastoid cushion is in the shape of a horseshoe.

Let me say here that the post-operative comfort of the patient after mastoidectomy, and likewise after any major operation, depends almost entirely on the skill exercised by the attending nurse. Prompt answer to calls, carefully smoothed pillows and sheets, attention to unusual symptoms and detailed report to the physician, a careful bedside manner, attractive arrangement of trays, a pleasantly ordered room, all these things are most important in the after care. Without these the most skillful efforts of the attending physician and the most rapid healing of wounds will be of little avail in making the few weeks in the hospital pleasant for the patient. This may be his first and only hospital experience, and he may always afterwards think of his hospital room as a place in which to undergo disagreeable experiences; or he may blame his physician for choosing such a poor institution. Fortunately, today hospitals and nursing schools have become so standardised that good service is the rule, and the doctor can confidently expect excellent treatment for his patients.

The wound during the first week after the operation will require very little dressing. The pain on moving the patient's head and any manipulations around the wound is very acute during this time—in fact, in certain cases the first few dressings may have to be done after the patient has been given enough gas to render him insensible to pain. Unless the patient has considerable fever, or a large amount of secretion accumulates in the lower end of the wound, it is not necessary to disturb the gauze wick for four or five days. The outer dressings should be removed daily. On the second day, if the temperature is high, the packing should be removed and the pus let out. The secretion may be expressed by stroking the wound lightly from above downward. At times when there has been considerable destruction of the bone small spicules will appear at the lower end of the wound and can be removed easily. When the secretion is very profuse a little suction may be used, and the cavity flushed out with a small amount of Carrel-Dakin solution. This you will remember, is a solution of hypochlorite of soda and was used extensively during the war to keep wounds bacteria-free. It depends on the production of nascent chlorine for its remarkable antiseptic properties. While it is not used so extensively today as it was during and following the war, it is still a most valuable cleansing fluid for wounds. When the flow of pus is very free, it may even be necessary for the surgeon to enlarge the opening somewhat and promote better drainage. However, if good foresight has been used at the time of the operation, and if the operator has understood the virulence of the infection he has to deal with, this should rarely be necessary.

In the more favourable cases with little or no fever after the second day, only the outer dressings are changed daily and the wound inspected. By the fourth or fifth day the packing will have become well saturated with secretions and can easily be separated from the surrounding tissues. Before this time it is rather firmly adherent and considerable pain is caused by pulling on it. The wick, after the fourth or fifth day, is withdrawn daily, and pressure is exerted from above downward on the wound with a pad of sterile gauze. This presses all secretions down to the outlet. This procedure is carried out until the wick is no longer needed. The sutures of the wound are removed on the fifth or sixth day—sooner than this if the wound should show any signs of infection.

Two or more weeks after the operation the exudate from the lower angle of the wound will have practically disappeared in the usual course of events. The drain is then left out, and the edges of the wound are brought together by the use of a small piece of adhesive plaster correctly applied. This is attached in front to the back of the auricle and posteriorly in such a way that the ear is drawn slightly backward. If the wound is clean, healing will take place rapidly, and new epithelial tissue will close over the wound where the wick formerly emerged.

At times granulation tissue, a small amount of which is present in all healing wounds, may be abundant and is best dealt with by a few applications of 100 per cent. silver nitrate. A boric acid powder dressing and a tight bandage are applied following this; only a few applications will be found necessary.

Again the amount of pus from the mastoid cavity may be excessive and quite difficult to handle. Long after the expected closure of the wound this cavity may still be draining. We have already spoken of suction and the use of Carrell-Dakin fluid in washing out the space. Another useful measure is the filling of the cavity with the ointment of ammoniated mercury, which is not only a good antiseptic, but also tends to promote healing.

From three to six weeks is necessary for the complete healing of the mastoid wound. We may consider as early recoveries those that heal in three weeks. For no apparent reason the healing may at times take much longer than this.

It is needless to say that poorly nourished individuals and those that have poor resistance to disease and infection will require the longer time in healing. Much has been written about the occurrence of mastoid disease in undernourished infants. Any of you who have been engaged in work in large pediatric wards will recall the surprising incidence of middle ear and mastoid infections in this group of infants. The story is very much the same—the baby has been hard to feed since birth; it may have gained a little weight at the start, but in a few weeks or months has began to lose. It is brought to the hospital as a feeding problem; in a great number of cases middle ear disease or mastoiditis or both will be found. The course in the hospital is as a rule discouraging. An emergency mastoidectomy may be done; at times the bilateral operation is necessary. The death rate is unfortunately high; the terminal picture is that of a bronchopneumonia. Why the percentage of mastoid and middle ear infections in these marasmic children is so high constitutes a pediatric problem of great importance. A number of the best pediatricians and otologists in this continent and abroad have tackled the problem, and it is to be hoped that our knowledge will be so increased in the next few years that we can save many of these lives. The best we can say today is that the undernourished body affords very little resistance against infection and it is well known that the middle ear of the baby is highly prone to disease. The care of these infants after mastoidectomy presents a real nursing problem and calls for extreme devotion in the face of overwhelming odds. That a fair percentage are saved is no doubt due as much to the care of the nurse as to the skill of the operator. Blood transfusions in small amounts may be necessary and at times are attended with good results. The feeding of these children post-operatively becomes a major problem; they are often the victims of a continuous diarrhea and many changes in the feeding formula may be necessary to control this distressing symptom.

In the foregoing paragraphs I have tried to visualise for you the routine after care of the simple mastoid operation. It is needless to say that a number of complications may occur which will cause these procedures to vary greatly. The bilateral mastoid operation may have been done, and of course increases the difficulty of the after care and makes the prognosis more guarded. I have indicated to you at least one of the difficult types to care for after operation—the undernourished, marasmic infant. There are many other causes of a poor resistance to infection; and factors that result in tardy healing of the wound: syphilis, marked anemia, tuberculosis, perhaps diabetes. Prompt and thorough treatment of these underlying maladies will do much in bringing about a favourable healing of the mastoid. Finally, it is well always to remember that we are dealing not only with an area of diseased bone which for the moment demands surgical and nursing care, but more particularly we are concerned with an individual who is oftentimes critically ill and whose life may depend on the amount of resistance we are able to add to his body's depleted store.

Common Ground

By ETHEL I. JOHNS, Director, Committee on Nursing Organisation of New York City Hospital, New York.

I am taking for granted that any group of nurses provincially organised will be composite in its membership and that in a meeting such as this there will be representatives of all the principal branches of nursing; further, that this drawing together of the various groups presupposes a common background, common interests, and a common aim.

For me the term Common Ground has an undertone of meaning which implies a pause for breath: an opportunity to stand still and to look back over the road we have travelled, as well as forward to that which lies before us; an overnight camp, as it were, on common ground, and a friendly talk about the adventures of the day's march.

In the last quarter of a century nursing has travelled fast and far. There is possibly no other calling which has developed more rapidly or extensively. Now perhaps this period of expansion is over and we are entering another phase: a more difficult, less spectacular phase, that of finding our real level in the community of which we are a part. That nurses are vaguely conscious of this change is shown by the surveys now being carried on not only in Canada and the United States, but even in certain European countries.

In the United States the driving force behind their survey and the chief cause of unrest among American nurses is economic maladjustment. There seems to be a general impression that there is more competition than there used to be, and in some phases of nursing much more unemployment. It has been made clear that not all nurses, whether institutional, private duty, or public health, manage to put by enough to keep them in their old age It is claimed that there is over-production of nurses, and that if the training schools continue to pour out increasingly large classes the unemployment problem will become unmanageable.

On the other hand, the committee's findings are being challenged. The counter-claim is being made that faulty distribution and not over-production is the real trouble, that there is plenty of work to do and not too many people to do it if certain adjustments could be made. Influential members of the public claim that if hospitals, public health agencies, and nursing organisations would get together and present their case, and show a willingness to make a few courageous experiments, the economic situation would improve and the unemployment problem be alleviated.

To what extent nursing conditions in Canada are similar to those in the United States can only be determined when the final report of Dr. Weir's survey is available. After hearing his preliminary report in Regina last summer my own impression is that the similarity is marked so far as the financial aspects of the situation are concerned. In the United States it is apparent that the private duty nurses are feeling the pinch more than the other groups. Whether that is true in Canada you know better than I do.

The questions I should like to ask are these: If it is admitted that certain changes are inevitable, both in our educational system and in our business methods, who should take the responsibility of making these changes? Is it desirable that the private duty nurses should fight their battle alone? Should hospital nurses and public health nurses confine themselves to the problems of their own particular group? Or should we all get together and try to find common ground? Your answers to these questions will show whether or not you are a dyed-in-the-wool specialist.

(An address given before the Registered Nurses Association of Ontario (District Five), Toronto, November 19, 1930.)

Do not misunderstand me. I am not making any sweeping criticism of specialization of function. It was inevitable, once the earlier years were past, that nursing should develop along specialized lines—that some should choose hospital work, some bedside nursing, others public health, or teaching. This development of special skills and aptitudes is all to the good. But now there seems to be an increasing tendency toward specialisation, not only in function but in form of organisation. By this I mean a rather clear-cut distinction between hospital nurses, teaching nurses, public health nurses, private duty nurses, with respect not only to their work but to their professional group activity, and even to their professional thinking.

There is something to be said for flocking with one's own kind. One cannot feel equally at home in all the "sections." As a battle scarred veteran of the hospital field, I feel at home in that group. When it comes to private duty my feelings are a bit mixed. I have done private duty and, in the innocence of my heart, once offered some advice (in public) to private duty nurses. To say that I was properly chastened for my temerity is to put it mildly. You have only to consult the back numbers of *The Canadian Nurse* to see what happened to me. But even that didn't make me stop. I still cherish as one of my happiest memories a refresher course we arranged for private duty nurses at the University of British Columbia. There never was a more responsive group. They came early and they stayed late. No use telling me that private duty nurses are not interested in education and administration. They are, if you give them a chance.

If I must confess it, it is the public health nurses who make my blood run cold. I have a permanent inferiority complex in that connection. Psychoanalysis would probably trace it back to the fact that in my long past training days we got no chance to "carry the bag"—to get the feel of it—to know the weight of it, as student nurses do today. But I stand less in awe of public healthers than I once did. You see, in Europe I had to do a little public healthing myself. I know it will shock some of my audience to know that, totally without public health experience, and clutching Mary Gardner's classic in my hand as my only guide, I organised a sort of visiting nurse service in a remote town in Hungary, up near the Roumanian border. We needed that service in connection with a training school job—it just had to be done and there was no one else to do it. Later on a colleague from the Paris office, a public health nurse, came out to look the job over. She shuddered at intervals and turned pale at others. Fortunately, the records were in Hungarian, so she will never know how bad we really were. However, when the looking over was done, she said: "Well, I wouldn't have believed a hospital woman could even have made a shot at it."

A year later I went out to look at a training school job she had had to see through. It was a good job, too—but did I admit it? Certainly not. What I said was, "Well, considering a public healther did it, it is a wonder it isn't worse." We grinned amiably at each other, for perhaps we had begun to learn that on the western side of the Atlantic these distinctions are sometimes taken a little more seriously than they need to be in the Balkans.

If it is agreed that specialisation ought not to go so far that it threatens professional unity, what can be done about it? There can only be one answer to that question. Seek common ground from the beginning. Develop an educational system which will give every pupil nurse an elementary understanding of all the principal branches of nursing. You will note that I say an elementary understanding, not a specialised proficiency. Let her "carry the bag" under the supervision of a public health nurse who is also a teacher. The terms are not always synonymous, you know. Let her watch at close range and actually assist a private duty nurse who is also a teacher, to care for a patient in a middle class home. Let her continue to undergo the chastening influence of the regular hospital grind—and when she has undergone the wholesome discipline of all three experiences, then, and then only, let her specialise.

After the training days are over, what then? Will the bond of understanding still hold? After all, what common ground have we? Would you agree that we have a common interest in learning to be nurses and in teaching the women who shall succeed us to be nurses? I am sure you will all admit that we have. Are the public health and private duty nurses right if they say that hospital administration and nurse education are none of their business? Does not the training school still give basic training to women desiring to enter the public health field?

It is true that in Canada and in some of the European countries notable experiments are being made in orienting the course toward public health from the beginning, but I know of no experiment so drastic that it aims to exclude hospital bedside experience entirely. The public health nurse cannot dissociate herself from what concerns her, both as pupil and as teacher.

The training school gives, or claims to give, basic training for private duty nursing. Is it not remarkable that it is the exception rather than the rule to find a well-organised, well-taught series of lectures and demonstrations on the special problems and the special skills of nursing in the home given to student nurses by private duty nurses? They alone are qualified to give such instruction. Are they always asked to do so? Do they always respond when they are? And yet a private duty section in any association might well render a great service by organising such a series, and selecting from its membership women capable of giving it. Perhaps you have done it here. If so, I wish you would let me have your outlines and borrow your teachers for use in other more backward parts of the continent.

It is certain that hospital executives cannot claim the right to disregard private duty problems. A large proportion of private nurses work in hospitals, and mutual understanding is essential if a proper working relationship is to be established. It would be interesting to make an experiment or two in this connection. Suppose a representative of the private duty group went on duty in the training school office for a week—just to see what it feels like in that supposedly peaceful haven on a busy Monday morning, for example. And supposing —just to even things up a little— that one of the younger and more self-confident of the training school staff took a good, hard, 24-hour private duty case once in a while. Then they could talk it over for the benefit of their respective "sections" at the next meeting of the Graduate Nurses Association. It would be a lively meeting, well worth attending, and it might foster mutual respect for the other fellow's point of view.

Surely the superintendent of nurses, usually made responsible for everything, from the elevator boy to the chief surgeon, might be excused from worrying about public health. It hurts me to acknowledge it, but it is just possible that the hospital executive might learn something from the public health nursing executive about staff education. There are public health nursing services whose efficiency is largely due to the enlightened manner in which they instruct their young recruits, and prevent their old guard from getting set in their ways and rusty in their thinking.

There was a time when nurses engaged in the administrative and bedside nursing phase of hospital work felt they had no responsibility for teaching the pupils. That unhappy state of affairs is passing. There is renewed emphasis on the importance of the head nurse as a teacher, and an effort is being made in progressive hospitals to give her a chance to do bedside teaching. It looks as though administration and teaching insist on mixing in spite of well meant efforts to keep them apart.

There is nothing desperate about our professional state: possibly nothing worse than growing pains. After a period of extraordinary and perhaps too rapid expansion, it may be good for us to undergo a little wholesome deflation. The survey ought to show whether there is overproduction of nurses in Canada or not. It will investigate faulty distribution. We shall be better equipped to interpret its findings and to put its recommendations into practice if, in the interval, our professional groups get together and listen to each other's troubles. We may find that hospital and public health executives and private duty leaders could work out schemes which would benefit all concerned. The public would be more inclined to listen to us and to help us if we knew our own minds and spoke with one voice. If in the process we get a little mixed and are no longer quite sure whether we are members of the public, or hospital workers, or nurse educators, or private duty nurses, or public health nurses, no great harm will have been done. Perhaps we shall find that we are no more and no less than just plain nurses after all; yes, and members of the public too.

In closing, I should like to suggest that your provincial organisation ought to constitute a forum for informal discussion of all common problems. Here, if anywhere, you find common ground. The private duty nurses meet with hospital executives, and the public health nurse with both. Would you think me presuming if I suggested a few topics? What would you think of some frank talk about the following questions?

1. Is the present situation with respect to general duty in hospitals satisfactory to—
   (a) The hospital?
   (b) The general duty nurse?

If not, why not? Has this whole question any relation to private duty nursing? Could it be studied *together* by both groups?

2. How should registries be organised and directed? Should registries exercise any degree of supervision over the nurses who obtain employment through them? Public health nurses accept supervision and seem to thrive on it. Have they any suggestions to make in this connection to the private duty group? Why not talk it over *together?*

3. If it is true that nurses commonly fail to make provision for retirement and old age, could a sound contributory retirement allowance scheme be worked out? That very thing has been done for teachers. Why not for nurses? It is just here that the nursing profession needs help. Without the advice and direction of experienced business men we shall not succeed in putting our house in order. Co-operative undertakings of any kind are essentially business enterprises and must be established and conducted in accordance with sound business methods. We shall not be called upon to sacrifice our professional independence nor our ideals in education if we show a willingness to face the issue squarely and to come half way with respect to adjustments. The people whom we serve are content that we shall specialise in our skills as much as we like, but they insist that, from the economic point of view, we get together and help them find a way out.

We must remember that people do not understand what we call professional specialisation. To them a doctor is a doctor, not a pediatrician or a dermatologist. Similarly, a nurse is a nurse, no matter what branch she specialises in. To the public both are people who may reasonably be expected to help when one is ill, but who, for some reason, do not always fulfil that expectation. No branch of nursing is so firmly established that it is independent of all the others. Much remains to be done before we can really claim to be a profession at all. Listen to what Dr. Weir has to say about the quality of our teaching in schools of nursing. If you have courage, read his grisly comparative table, which puts the nursing group at the bottom of the list as far as intelligence tests are concerned. Better get together and do something about all that. No one group can do it by themselves.

Those of you who know England will remember the open fields one finds even in London, which are spoken of as the Common. They are not parks, they are not gardens. They are a sort of wild land, open to the sky. Places where people have a common right to seek the sun and the air: ground which, because it is shared by all alike, becomes in some mysterious way not common but holy ground.

The Pre-Operative and Post-Operative Care of Torticollis

By **JEAN S. BANCROFT**, Assistant Instructor, Children's Memorial Hospital, Montreal.

Pre-Operative Care

The patient is admitted to the hospital usually two or three days before operation to allow for adequate preparation. In older children, massage treatment and corrective exercises are used before admission in an attempt to correct pre-operatively as much of the deformity as is possible.

After admission, the head is shaved and the patient sent to the plaster room for the application of a short plaster cast reaching from the neck to the waist, and a plaster cap to include the head. These are removed separately and kept in the plaster room to dry.

The day following, a local preparation of ether, alcohol, and picric acid is done. The area is covered with a sterile towel, which is secured with a bandage. The patient is then given the routine preparation for general anaesthetic.

Post-Operative Care

On returning from the operating room, the patient is placed on a Bradford frame and restrained with a frame apron. Sometimes it will be found necessary to restrain the hands also.

The head is fixed in position with two sand pillows, tilted slightly backward, and rotated towards the affected side, thus over-correcting the deformity. A wide strip of adhesive may be placed over the forehead and attached to the sand pillows on either side, thus fixing the head firmly in position.

Two Days Post-Operative

The patient returns to the operating room and the plasters are applied; the plaster cap and jacket being incorporated by means of zinc strips reinforced with plaster bandages. A window is cut in the plaster to allow for the dressing of the wound and the removal of the sutures.

The patient is then placed in bed, on a back rest, supported on either side with pillows.

The plaster is not applied until the second day post-operative to prevent the possible soiling of the cast by ether vomitus.

Seven Days Post-Operative

The sutures are removed.

Fourteen Days Post-Operative

The patient is usually discharged in the plaster cast, which he continues to wear for six weeks.

When it is bi-valved and removed, massage treatment is instituted until a complete cure is effected.

Libraries and Hospitals

By HELEN G. STEWART, Ph.D.

It is a little difficult to talk about libraries in a clear-cut, direct way, because the idea of libraries has become so sentimentalised in the past generation or two, that before getting down to tacks, one must clear away a lot of sticky sentiment and fog which surrounds it, and present it as a practical, not to say urgent, proposition.

People are so obsessed by the traditional values of books, that their real place in modern civilisation eludes them. The clouds of glory trailing from the past have a habit of completely veiling the discrepancy between the funny little antiquated assortments of odds and ends and left-overs, so often dignified by the name of Libraries, and the reading needs of a modern community or institution.

Practically every hospital board in the country is willing to admit on principle that libraries have a place in their general scheme of things because they have been brought up in this belief. Yet those who are willing and able to translate that principle into a concrete policy, and more especially to have those policies sufficiently concrete to appear on their actual budget as in the case of stenographic help, or laboratory equipment, are as hard to find as roses in snow drifts. Some few books have been purchased, but purchased for a specific purpose. When one realises that in the whole of British Columbia, and I am speaking of British Columbia in so far as the report of the Library Survey Committee is concerned, when one realises that in the year 1926 the immense sum of $370.00 was expended by all of the hospitals put together for books and periodicals, one can realise that as far as a purposeful policy is concerned we have a long distance to go. In this province of British Columbia, according to a survey made in 1927-28, well over one-third of the forty-one hospitals from which information was gathered reported that they had made no provision whatever for library service. The rest maintained some sort of a collection, ranging in size from 50 to 70 volumes, but only one found a place in its regular budget for reading material. The total book stock of 25 institutions fell short of 5,000 volumes, and one gathers from the Survey Report, that most of these have been accumulated in a casual fashion, through book drives and private philanthropy.

I may say right here, that so far as my own knowledge goes I do not think that British Columbia is very much behind certain other parts of the world in that respect. The trouble has been, to a certain extent at least, that the world has got ahead of us, and, in relation to the professional hospital libraries, the little libraries that are now operating under that name are in many cases more or less hang-overs from a distant past. Boards and doctors and nurses have been so obsessed in the past with the idea of the traditional values that they have failed utterly, in many cases, to see the real value of, and the real necessity for, the books in any scheme which a modern world demands from them. Just what these needs are, it is not quite so easy to say. Libraries, in so far as hospitals are concerned have been, up to date, desultory affairs, usually casual. No mention was made in any of these reports of librarianship, or of any adequate facilities for selection and organisation. Indeed no person seems to care enough about the whole matter to keep any special record of what these collections of

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books do to further the interests of the institution. Some appear to be set aside for staff use, and to contain at least a few works of purely professional interest. Some are earmarked from the start for the patients. In most cases, and now I am speaking with very little direct knowledge, the patients' library consists almost entirely of books which have been donated in one way or another, generally by hospital auxiliaries or organizations of that kind.

Most of the purchasing which is done for the staff of the hospital is done having regard to professional books, but as far as I can gather, even these books are purchased in a more or less desultory fashion, without a very large knowledge of the whole field of professional literature or, on the other hand, without any very technical use of what we call the essential tools of selection and organisation for purchases of that kind. And while hospitals the world over, with few exceptions, are in the same position as we ourselves in this regard, the real urgent need for some definite plan of library service in hospitals, as in certain other institutions, becomes more and more acute every day. There is an immense flow of books coming from the publishers, which never seems to end, hundreds, thousands, tens of thousands, flowing out every year, so that even the greatest expert cannot do more than have a nodding acquaintance with the outlying parts of her own particular field. With the constant flux and change which throws yesterday's theories into the scrap heap, with the increasing specialisation of specialists and the increasing need for orientation and the expansion of community boundaries, some clearing house of specialised information and knowledge becomes more and more imperative.

Whether you realise it or not, the day of the vague, general, desultory library is over. What is coming to take its place is an effective tool, shaped to the hand of its user. A modern library is as much a matter of supply and demand as is a modern departmental store, and it requires as much skill and subtlety in its successful operation—which does not at all mean that it must be put on a purely materialistic basis, but that its policies must be the result of conscious effort and the measure of its achievement not merely a matter of wishful thinking. It must be purposeful and focussed; adapted to the needs of a special clientele and operated with as much knowledge of processes and techniques as a laboratory is operated. It is a difficult thing to run a library on these lines. There is nothing casual or desultory about it. It is an expert's job. It is especially difficult to organise such a service in small communities. It needs a range and scope hard to attain except where there are people and money. Isolated efforts or small units, however much enthusiasm goes into them, are bound to fail, to become stagnant pools or shallow marshes instead of swift-flowing, useful streams. It is partly because hospital libraries have almost always been little isolated efforts that so many of them fail. I know very little about hospital libraries and therefore I will probably make a number of mistakes while here today, because hospital libraries are not a speciality of mine, but I will say this, that because public libraries and other kinds of libraries are going through about the same stage as hospital libraries are at the present time, perhaps some of our own experiences may be of a certain benefit to those of the rest of you who are fumbling about for some way out of a difficult position.

My position at the present time is in connection with a library experiment which is being tried out in the Fraser Valley. This experiment is financed by the Carnegie Corporation from New York City, and the reason they are giving money to finance this experiment is simply because the library focus has so changed in the last number of years that the old methods, which were adequate enough a generation ago, have fallen down and failed. The new methods which are necessary in order to run a library, particularly in a district where the population is more or less scattered, now demand a certain type of focus without which almost any kind of library project is doomed to failure. Now hospital libraries, like public libraries in rural communities, have up to the present been isolated units, cut off from their own kind. They have worked by themselves and through themselves and for themselves and those who have been responsible for them like "Elijah under the Juniper Bush" have wrestled away with their own problems not knowing there was any person else with the same problems or the same interest. Both hospital libraries and public libraries in small communities are likely to see in the near future a change very much for the better through the use of these two ideas of focus and federation, and it is along these lines that progress may be expected.

Before suggesting any of the practical ways, I think it might be very well to discuss a little more fully for one moment what the hospital libraries might do. What is their responsibility; or what would they have to take into consideration in the way of operation before any concrete plan was definitely adopted? As we have said, the natural division at the present time seems to be professional and patient, but each of these classes will stand a little dividing. As I see it, although I know very little about hospitals, a hospital library has not only an opportunity, but a definite responsibility for the supply of certain kinds of reading needs. First, in connection with the student nurses in training. A hospital accepts students and exacts from them long hours of service for a period of three years on the strength of giving them a professional education, but they are not giving them in return a good professional training. The craft part of their training they can get probably well enough, in the way all other apprentices do. But professional education demands a knowledge of principle as well and also an ability to think creatively, and this cannot be imparted to the students without a minimum supply at least of the tools of learning. There should be a sufficient number of up-to-date text books to give various points of view on the actual subjects taught. There should also be books giving the cultural background of these subjects and their relation to other knowledge; material linking up their professional specialty with the social environment in which they must practise it, and finally a constant supply of material to help their personal development during these years of training. No school professing academic standards can do less than this, in fairness to its students and to its own professional reputation.

No professional staff can grow and progress today if cut off from the thought of their kind. Once responsibility for such mental alertness rested with the individual. but today it is far from being an individual matter. No big firm today would dream of running a chemical laboratory, a patent office, a trust company or an international banking concern without having a highly effective library at the centre of their organisation—not only books, but hundreds of magazines selected and classified for the use of their busy and alert staff. It is only the professionals, once the centre of the reading tradition, who fail in this regard, or strain their personal resources to the breaking point to keep up with the demands upon them. Nurses and doctors alike need service of this kind, and indeed without it cannot possibly hope to take the place expected of them in their community. As in the case of the students, there is also the matter of a broad, cultural reading for the professional staff and those who live an institutionalised life have a right to expect that a part at least of these needs will be satisfied by the hospital itself.

Then there is the question of reading for the patients. From a standpoint of direct therapeutic value, reading offers large possibilities scarcely more than hinted at, at the present time. Again my ignorance stands in the way of saying anything very definite about these possibilities, but I am practically certain that before many years pass it will be quite possible to make up reading diets in the same way as one is able to now make up regular food diets. It is altogether likely that normal reading needs call for certain vitamin contents, certain calories, certain salts and minerals, fluids and roughage, as much as diets do, only no person knows enough about them yet to say what they are. Certainly from a standpoint of suggestion and inspiration, from a standpoint of purposeful study, from a standpoint of making up shortages and satisfying hungers, books selected and organised and administered properly can do much for both the mind and the body of all but those who are very, very ill. But there must be a conscious plan about it all.

There may be other uses for a library, but it seems to me that a hospital library might very well be the professional centre in any event for the reading matter for the whole nursing and medical profession, and with certain limitations, that is a matter which could be worked out later. If one takes anything like that view of hospital libraries, if one admits for a moment that there is anything like that responsibility which I have mentioned resting upon them —and it seems to me you cannot get away from it—then the question arises how can a hospital library be operated in such a way that it can fill some of these requirements? I have stated the isolated hospital libraries are almost doomed to failure from the start. I think hospitals might see their way clear to work out the same sort of scheme that is being tried in the Fraser Valley experiment. That is, in place of having little libraries, one in Chilliwack, one in Mission, one in Abbotsford and one in Haney, etc., the experiment is to pool resources and to pool interests, and with these pooled resources to prepare a programme which can support a larger scope and range of books, a highly trained staff and give to readers in the Valley a number of books and a range of books that would be absolutely impossible in any one of these isolated library centres. There does not seem to me to be any reason why, for example, the hospitals in British Columbia should not federate under one large hospital library scheme by having one large common stock of books arranged in this way. We have a rural bus which carries the books from one branch to the other. I do not see anything insuperable in the way of some sort of regional depots which would make it possible and practicable, that is, to have the minimum basic supply of books in each of the hospitals and then a large common stock which would keep rotating so that the hospitals would have the advantage of having one highly trained staff which could operate the whole thing, could organise, advise, help and classify. One supervising staff could supervise and arrange in the smaller hospitals where a trained librarian would be quite out of the question, and it would seem that your problem could be worked out with the maximum of effect and with a minimum of cost. If our present scheme in the Fraser Valley can be put through, it will give every person in the Fraser Valley, no matter how far away from the centres of population, by the end of the five-year period, a choice of some-

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thing in the neighbourhood of 50,000 volumes, and I think we can do that at a total cost eventually to the borrower of something like 30 cents per capita, which does not seem to me to be exorbitant. That includes a highly trained staff and also includes the most up-to-date and best type of library service which has been worked out up to the present time.

If the hospitals in British Columbia are at all interested in that sort of thing, I would say that now is the time when they can make that interest rather effective. This demonstration of which I have been speaking, is a demonstration which is financed for a five-year period, and during that five-year period it is our business in the Fraser Valley to do everything in our power to further the library interests in any field. A certain amount of work that should be done in the hospitals is out of our jurisdiction, that is the highly professional type, but what we could do during this five-year demonstration, if the Hospital Association of British Columbia wish to take advantage of it, is first of all to place at its disposal the experiences which we have had in the working out of our own problems; secondly, to help in the way of suggesting the lines of tools, etc., in selecting books, and I may say that is a very highly specialised type of work at the present time; thirdly, since our territory lies in the Fraser Valley it is also within our power to set up within the Valley a hospital project, just as we intend to set up a school project and various special interest projects, which we would work through on a regular laboratory basis to the best of our ability. It seems to me if the hospitals would take advantage of this opportunity sufficiently to get their plans made they would really reap a very great deal of benefit from the generosity of the Carnegie Corporation, and there is no reason why you should not benefit from it as well as others.

I would think if the Hospital Association wish to do anything along that line, they should first of all form some kind of a working organisation within the Association which would in the first place get a little more information about what actually exists in the hospital libraries today. No person knows very much about it. No person knows what books are considered educational, or how they should be used. No person knows what the real needs of the hospital community are, and that is something which could be shown by a committee gathering that information together. Then there is a great deal to be gained in the way of the researches available in the realm of professional matter. Hospitals are at present getting no benefit at all from such research. There could also be a good deal done in the way of studying the actual needs of your hospitals. And then after these things were done, or while they were being accomplished, a definite scheme could be worked out whereby the assistance of the Carnegie Corporation could be gained in the project of which I speak. I may say, as far as we are concerned, we would give every assistance to any such committee, and if there is any way that we can help through this particular matter of specialised libraries for the hospital, you may call upon us for anything that comes within our legitimate field.

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A Simple Method of Artificial Feeding in Infancy

By H. P. WRIGHT, M.D., and A. K. GEDDES, M.D., Montreal.

Recent work has focussed attention on simplified feeding in infancy. There are many simple methods and it is not improbable that a too simple method may defeat our purpose by depriving physicians of proper supervision during a period of life when constant watchfulness is important. Paradoxically, one begins to feel that the reason why so many infants do well on complicated formulae is not on account of the merit of the various formulae but because of the capacity of the infant to make progress, provided it is supplied with the minimum amount of fat, carbohydrate, proteins, salts, vitamins, and total fluid. We use the word "minimum" advisedly, because if more than this minimum is supplied often there is no apparent harm if each ingredient does not fall below the requisite amount. As a matter of fact, it is since the value of the accessory food factors has been appreciated that we have learned the relative unimportance of the actual food factors, provided always that certain minimum requirements are complied with and that sufficient calories are supplied.

Berlin, the academic home of infant feeding, well exemplifies this argument, for at one end of the town infants do well on protein milk and its combinations and at the other extremity, butterflour, under the enthusiasm of Czerny, is with equal success used in the feeding of infants.

The story of our progress in infant feeding at the Montreal Foundling and Baby Hospital during the last ten years is of interest; for with every simplification our results have improved, until today we feel that our only remaining physiological problem is that one related with infections, and particularly those upper respiratory infections which are difficult to handle wherever infants are found gathered together. In the autumn of 1928 we decided to try a certain number of the infants on selective feedings or, in other words, to feed them by appetite from the following formula:

Lactic Acid Whole Milk	20 ounces
Corn Syrup (50 per cent.)	2 ounces

Our results have been so uniformly successful that it is thought worth while to describe them.

It is well recognised that Marriott has advocated some such feeding but his actual procedure during the first year was not known to us. We make no claim to originality but simply wish to record a simple, satisfactory method which we have been using. After our success with lactic acid milk we were encouraged to try the same sort of feedings without acidification, but this work has not progressed sufficiently to justify any conclusions. We have had no experience with Weissenberg's citric acid whole milk. We are continuing our experimental feedings and at the end of another year hope to have more established ideas. In the meantime we submit a method which is simple and workable, although probably no more simple or workable than many others. This work is being carried on at the Montreal Foundling and Baby Hospital and no success could have accrued had it not been for the very efficient co-operation of Miss Lawrence and her capable staff of nurses, for we all know too well that there is no food that can be successfully fed to infants if they are not well cared for.

(The Canadian Medical Association Journal, XXIII, 1930.)

The caloric value of our standard lactic acid milk is between 23 and 24 calories per ounce, or slightly higher than breast milk, and the carbohydrate and protein both in greater percentages than in breast milk.

Our first rule was that all babies should be fed every four hours (5 feedings in the 24 hours) and for 20 minutes by the clock. Each baby, under 3 months of age was held while being fed. The ordinary anticolic nipple was used with a fairly large hole, so that one could reasonably assume that the infant would get as much as wanted during the 20 minutes.

Our second rule was that when a baby took 32 ounces of this formula in the 24 hours, cereals were offered twice daily and vegetable broth once, and the number of feedings was reduced to four. When the child was taking two platefuls of cereal it was usually fed only three times a day. This often meant in practice that infants of four months of age were eating cereal greedily, and at six months were receiving only four feedings in the 24 hours. Boiled water was offered to all infants between feedings. The most extraordinary variation in intake was found, which will be referred to in the case reports.

Cod liver oil was administered to all infants from the day of admission and rapidly increased up to 1 teaspoonful twice a day. Orange juice was also given from admission and quickly augmented to 1 tablespoonful daily.

It may be of interest to note that cod liver oil has never disagreed with an infant in the Montreal Foundling and Baby Hospital, although we venture to affirm that there is no experienced physician who cannot recall in private practice cases when patients seemed unable to take cod liver oil without gastro-intestinal symptoms.

It is not our contention that every infant will do well on this type of feeding, for it may require minor variations, but then neither will every infant do well on the breast without these minor variations, and we are inclined to believe that about the same percentage will make an uninterrupted progress on either method of feeding, provided always that the technique is good and no parenteral or enteral infections supervene. Neither do we wish to be understood as advocating that all infants should be fed according to appetite. Sedgewick and others have emphasized the variation in the amount taken at different feedings from the breast. Because of this difference no one as yet has suggested milking the mother's breast and feeding equal amounts from a bottle at regular intervals of three or four hours. Whether it is better to make the baby take a prescribed amount at each feeding or to be guided by the appetite must to some extent depend on the type of baby.

Our conclusion, therefore, is that it is perfectly safe to feed normal babies during the first year by appetite on lactic acid whole milk 20 ounces with the addition of 2 ounces of 50 per cent. corn syrup, at four hour intervals, five feedings in the twenty-four hours, and for exactly 20 minutes at each feeding, boiled water being offered between feedings and the accessory food factors supplied in adequate amounts. And furthermore, we are inclined to believe that some such simplified feeding as outlined above is safer to place in the hands of the busy general practitioner than one that requires to be modified at regular intervals.

The following case reports are representative of those of twenty children who up to this time have received the feeding described. Only two infants of the series failed to make satisfactory progress; one had congenital syphilis and the other a cerebral haemorrhage resulting from birth injury.

Case 1

Philip W., aged two weeks, admitted December 26, 1928; weight 6 pounds. On discharge fifty-two days later he weighed 9 pounds, an average gain of 7 ounces per week. There was occasional regurgitation, but no vomiting. An upper respiratory infection in February had no effect upon the fluid intake.

Case 2

Annie M., aged 3 weeks on admission; weight 7 pounds 4 ounces; fifty-four days later she weighed 10 pounds, an average gain of 5.5 ounces per week. Except for one mild upper respiratory infection, her stay in hospital was uneventful. She took from one to seven ounces at a feeding, the duration of which varied from five to twenty minutes. She had two to four pasty stools per day. There was a moderate amount of regurgitation and the record says vomiting occurred seven times during the fifty-four days.

Case 3

Evelyn W., aged 1 month on admission; weight 7 pounds. In 4 months there was a weight gain of 6 pounds, an average gain of 6 ounces per week. Cereal was added to the diet at age of 3 months. There were no infections, and her progress was uneventful.

Case 4

Arthur T., aged 2 months on admission; weight 9 pounds 2 ounces. Marked variations in milk intake, which ranged from 21 to 42 ounces per day. No vomiting; very little regurgitation; one to five pasty stools per day. The addition of cereal at the age of 3½ months was coincident with an abrupt rise in the weight curve, but there was no decrease in the quantity of milk taken. During two upper respiratory infections in November and December, he continued to gain weight and to take the usual quantities of milk. During a very severe infection in April formula withdrawn for two weeks. The illness caused a loss in weight of 2 pounds 6 ounces in 2 weeks; this was recovered in the following three weeks. The average weekly weight increment for total seven-months' period was 5 ounces.

Case 5

Warren T., aged 3 months; weight 8 pounds, a premature infant, admitted at age of 4 days, weighing 3 pounds 8 ounces. He was given an evaporated milk formula until his transfer at the age of 3 months to the group receiving the special feeding. The weight gain thereafter averaged 7.5 ounces per week. In March, an upper respiratory infection, with otitis media and fever, did not influence the food intake or the weight increment.

Case 6

Margaret H., aged 6½ months on admission; weight 7 pounds 14 ounces; length 22 inches; bilateral purulent otorrhoea. The milk intake varied from 28 to 44 ounces per day. The monthly weight increments were: first month 3 pounds; second month 1 pound 13 ounces; third month 3 pounds 11 ounces; fourth month 2 pounds 10 ounces, giving a weekly average of about 10½ ounces. At the age of 9 months, length was 26 inches. In February there was a recurrence of the otorrhoea in the presence of a rising weight curve.

Case 7

Walter W., aged 6 months on admission; weight 13 pounds 4 ounces. He took huge quantities of the formula without evidence of discomfort. On four occasions, he took over 50 ounces of milk in 24 hours, and on one occasion drank 13 ounces in 20 minutes, four hours later 9 ounces, and again 4 hours later 12 ounces. During an acute upper respiratory infection, with fever rising daily to 102° F. for a week, he reduced his milk intake to a level of 21 to 35 ounces per day. His average gain per week for a five months' observation period was six and one-third ounces.

Case 8

Maisie C., aged 7¾ months on admission; weight 10 pounds. Large quantities of the formula were taken in addition to solids. Her average weekly weight gain over an observation period of four months was 9½ ounces.

The Breath of Life

By H. J. FELLS, B.A.

The breath of life, it will be remembered, was breathed into man's nostrils. The civilised recipient, however, prefers to breathe through the mouth, which neither in its shape nor its properties is qualified for the task. That man utilises the wrong instrument is one of the ills of civilisation, bringing far more dire results than do the seven which a well-known sociologist decided were sapping the foundations of communal life.

It is, therefore, germane to the topic to refer briefly to the evil effects of breathing through the wrong cavity. In principle it comes to this, that breath inhaled through the nostrils is as different from breath inhaled through the mouth as distilled water is different from that in a dirty pond. The nose purifies the food of the lungs, and it is even claimed that there are mineral and vegetable poisonous odours which can do no harm if breathed through the nostrils, but are fatal if inhaled through the mouth. Mouth breathing also affects the human frame, to the extent that it is conducive to contracted chests and stooping shoulders. That diseases of the respiratory organs are more likely to arise through mouth breathing needs no stressing.

An interesting theory has been advanced—that mouth breathing during sleep causes dental decay, since the antiseptic qualities of the saliva are absent from the mouth, which goes dry when open. Further, the developing teeth of a child "feel" each other (as it were) on top and bottom gums when the mouth is kept shut, and thus emerge in regular formation. With mouth breathing this desirable result is less likely to happen. But all the dangers of mouth breathing must not obscure the fact that breathing in the form of talking is an excellent exercise and conducive to longevity. Those who object to any interruption of a sedentary mode of existence should, failing the opportunity or lacking the predilection for talking, read aloud for their own advantage even if to the advantage of nobody else.

During the first half of the last century, George Catlin prosecuted most detailed researches amongst the Indians of North America. He was struck by the fact that amongst them were born no idiots, no hunch-backs and no deaf and dumb. No mothers died at childbirth and infant mortality was practically negligible. Having pondered considerably on this happy state of affairs, he essayed the conviction that the reason for it was due to breathing through the nose. He was drawn to this conclusion by an Indian proverb—"No man is to be feared who cannot shut his mouth."

Catlin's premise was that healthy life depended upon quiet, refreshing sleep and that man was so constructed that his lungs promoted the condition in breathing during somnolence, since they regulated the digestion and circulation of the blood, as well as performing their main function. The lungs, however, depend for their treble functioning on a supply of air both soothed and temperate, and such characteristics are acquired only by air which passes through the nose.

Indian squaws watch their babies while sleeping to see that the mouth is kept shut, and if necessary, press together the lips of their children. Indians sleep on their backs, and do not permit that which serves as a pillow to rest under their shoulders. In this position the head is bowed a little forward, which aids in preventing the opening of the mouth.

A very spiritual conception of breathing is held in the East by a section of Hindus known as the Yogis. By rhythmical breathing the control of the body and spiritual development are inter-related. Rhythmical breathing might be described as breathing in tune with the universe. By such harmony the body assimilates the maximum of prana, or absolute energy, which is in, but not of, all forms of matter.

Western views do not go quite so far as this, though a school of scientific opinion recognises some correspondence between breathing and mentality (as in nervousness, which shows itself in irregular breathing). Breathing in its various forms accompanies all mental and emotional activity. Talking, in one aspect, is merely a modification of the normal respiratory movement, yet speech is the expression of the mind, even the expression of the inexpressible, as in St. John's conception of the Logos or Word. Sobbing, laughing, shouting, all are manifestations of emotional states, yet have all their definite and unbreakable relationship with the breath of life.

It has been said that normally Western man uses only twenty to thirty inches of air out of a possible two hundred and thirty. The air capacity of the lungs is scarcely appreciated, though this is not surprising in view of the fact that the air chambers, into which the bronchial tubes finally sub-divide, are estimated to number seven hundred and twenty-five million, covering a total surface of two thousand square feet.

At rest the average volume of air taken into the lungs each minute is one to two gallons. During exercise, however, as much as twelve to fifteen gallons a minute are consumed. According to Yogi ideas, clavicular breathing, or breathing by the raising of the collar bone, fills only the top of the lung, rib expansion breathing only the middle and abdominal or diaphragmatic breathing only the bottom.

These various methods of breathing have all had their vogue, particularly among singers. Many years ago abdominal breathing was favoured, and schools of singing had special apparatus to bind the chest, or else a form of pillory which pinioned the ribs. It was even said that singers practised in a horizontal position with heavy weights upon their chest, or if these were not forthcoming the music master himself would sit upon the chest of his pupil.

The Yogi way of breathing is a combined movement of all three motive forces, so that the lung is completely aerated. This, of course, does not mean filled to its maximum capacity. It does not entail a phenomenal alteration in the girth of the chest. Such remarkable results as "strong men" demonstrate in this connection are not due in the slightest to the act of breathing, but the cunning use of certain extrinsic muscles of the chest. Breathing exercises unfortunately seem reserved largely for these show purposes of chest expansion, whereas they can be used not only in the treatment of pulmonary diseases, but also in affections of the heart, for in such complaints attention should often be concentrated on the lungs. Even the fat may be suffering from defective oxygenation of the tissue due to inadequate breathing while those with a phenomenal thirst will, it is stated, lose the desire after taking a few deep breaths.

(From New Health (Eng.), May, 1930.)

Scarlet Fever Anti-Toxin

By ELLEN FRASER TAYLOR, M.D., Winnipeg Municipal Hospitals

Before giving the effects of scarlet fever anti-toxin one should recall the course of a fairly sick case of scarlet fever. They begin by being feverish and nauseated with perhaps headache and chills. In one to three days the throat becomes inflamed, with sometimes a slight or heavy exudate on the tonsils; the soft palate becomes injected; the tongue heavily coated — "the white strawberry tongue;" a punctate rash appears on the chest, rapidly spreading over the body. These signs remain three or four days and then gradually disappear. The tongue, about the fourth day, passes from the white to the red strawberry type; desquamation begins in the second week, taking in many cases the rest of the quarantine period to finish. At any time during the disease complications, such as adenitis, rhinitis, acute otitis media and mastoiditis may occur, prolonging the time in hospital to many weeks or months.

Scarlet fever anti-toxin has changed the above picture very much. To obtain the best results the serum should be given early, as it appears to do little or no good after the fourth day. One ampoule, approximately 12 c.c., is injected intramuscularly the same as in diphtheria and rarely needs to be repeated. Within twenty-four to thirty-six hours in the uncomplicated cases, the temperature drops from 102°-103° to 99°-100°, the rash fades; the throat symptoms become much easier; the tongue changes the same as in the untreated; desquamation may not take place if the rash was not well marked before the anti-toxin was injected. The patient makes an uninterrupted recovery and is discharged at the end of five weeks.

Those admitted with complications respond well to the anti-toxin. Adenitis disappears in ten days or less without suppuration; the aural discharge from those with acute otitis media clears in an average of thirty-two days. An operation is necessary when the mastoid cells are infected, but the healing time is shortened.

A serum rash occurs in about ten days in over fifty per cent. of the cases, a few having serum sickness, i.e., vomiting and adenitis. Calomine and soda bicarbonate lotions relieve the mild rashes but pituitrin is needed when the irritation is severe.

A study of five hundred cases over a period of four years leads one to believe that scarlet fever anti-toxin, if given early enough, shortens the initial stage and prevents complications, saving the patient both time and money.

Disease should not be endured, or even cured, if it can be prevented. It is wiser to maintain health than to regain it, and cheaper also. It is wiser to pay for a non-skid tire than for a smash-up and a police court fine. It is better to pay for safety in advance, and enjoy it, than to have calamity thrust upon us to be paid for on the instalment plan.

"The Story of the Year 1929-1930."
(Ninette Sanatorium, Manitoba).

Parliamentary Procedure

ALISON EWART.

I.

Parliamentary procedure is the law, both written and unwritten, for the proper and orderly conduct of meetings. The rules have not been adopted in any arbitrary manner, but are the result of the experience of administrative bodies during the last four or five centuries. They have been adopted because they have served best, in the words of Thomas Jefferson, "accuracy in business, economy in time, order, uniformity, and impartiality."

Parliamentary procedure guarantees democracy. It prevents the majority from exercising undue control over the minority. When it is understood by the majority it prevents the rule of a minority. In a word, it secures justice, courtesy, order, and efficiency.

There are two kinds of societies or organisations: societies which are incorporated by law and which must, therefore, conform to all the statutory requirements of the country in which they operate; societies which are voluntary, or unincorporated, which are not thus restricted and have greater freedom in the adoption of rules.

A society may become incorporated by adopting the articles of association in compliance with the conditions of the law of the land, which makes provision for the incorporation of such a society. Articles of association may be changed and by-laws adopted or amended only in the manner provided by law. The advantages of being an incorporated society are that the society has the power to acquire and convey real property and the ability to bring legal action in the name of the society.

A society, whether it is incorporated or not, should adopt a constitution and by-laws, the constitution incorporating what is fundamental to the society and the by-laws containing those details which may be changed without affecting the general character or work of the society. The constitution should be more difficult to amend than the by-laws.

An organisation, or society, holds four types of meetings—regular, special, adjourned, and annual. At a regular meeting a society is competent to transact any business except that which by its rules can only be transacted at an annual meeting. For instance, it is an almost universal custom to restrict the changing of the constitution to an annual meeting, and in many societies this rule also applies to the by-laws.

At a special meeting no business can be transacted except that which is specified in the call for the special meeting. Even the minutes of the preceding meeting cannot be approved, unless this was specified in the call.

An adjourned meeting is simply a continuation of another meeting. Any business which was in order at the former meeting is in order at any adjournment thereof.

Annual meetings are more formal than ordinary meetings. They include annual reports and the election of officers. The minutes of the preceding regular meeting may be read at an annual meeting, and the minutes of an annual meeting may be read at the succeeding regular meeting.

The President:

Every society should have at least four officers: a president, a vice-president, a secretary, and a treasurer. The president holds the position of highest honour and the greatest responsibility. The success and the orderly conduct of the meetings depend on him. It is absolutely essential that he be impartial, and that he have a thorough knowledge of parliamentary law. The president should be addressed as Mr. President, Madam President, Mr. or Madam Chairman, but never by name. He speaks of himself as "the chair," and he should never refer to himself as "I" in alluding to anything done while in the chair. He may speak of himself as "your president" when reporting something that he has done outside a meeting in his official capacity.

The duties of the presiding officer are: to be regular and prompt in attendance; to call meetings to order at the specified time; to preserve order; to entertain motions which are in order, repeat them, and at the proper time put them to vote; to repeat the motion under consideration or to have the secretary read it whenever asked to do so by a member; to announce the result of all votes.

It is customary for the presiding officer to stand while he is stating a motion, also while putting the motion to the vote and declaring the result. It is not customary to rise to recognise a member who wishes to speak, or to stand while the discussion is going on. But if the assembly is very large, he may better preserve order by standing.

The presiding officer should see that everyone's rights are observed, that no disorderly conduct is permitted, that motions not properly made are either corrected or ruled out of order; he, as well as the secretary, should sign all formal communications sent out by the society.

The presiding officer generally has the power of appointing standing committees, and often the power of appointing special committees. He is usually a member *ex officio* of all committees. (These details should be stated in the constitution.)

The presiding officer forfeits, however, the right to make, second, or discuss a motion. If he wishes to discuss a motion, read a paper, or make an address, he should call the vice-president to the chair, and then address the presiding officer, and observe the same rules as the other members. He does not forfeit the right to vote, but it is not customary for him to vote except when the vote is by ballot or roll call. He seldom exercises the right on a *viva voce* vote, even in the case of a tie. When the voting is by roll call, he gives his vote last. When the voting is by ballot, his vote is deposited with the others. It is to be noted that he is not compelled to vote in the case of a tie.

The Vice-President:

The vice-president takes the chair in the absence of the president or when he is requested to do so by the president. This request may be made when the president gives his annual address, takes part in the discussion of a motion, or for some reason is unable to preside. If the president is permanently absent, the vice-president becomes acting president, with all the powers and duties of president, but without special provision, he does not become president.

The Secretary:

The duties of the secretary are only second to those of the president, but, unlike the president, he does not forfeit any rights of membership by holding office. His duties are: to send notices of meetings and to send out all other notices; to call the meeting to order if the president and vice-president are both away, and to entertain the motion for a temporary chairman; to call the roll; to keep accurate record of all proceedings at the meetings, in the form of minutes; to keep the constitution, by-laws, and all papers belonging to the society; to count the votes when the vote is taken by raising hands or standing; to give to the chairman of every special committee the names of the members of his committee, and a copy of the motion referred to the committee; to prepare for the presiding officer an order of business and a list of all committees that should report at the meeting.

The Treasurer:

The duties of the treasurer are to collect the dues and fees and any other moneys taken in by the society,

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to pay all bills for the society, and to prepare a final statement for the annual meeting. The treasurer's books should be audited every year.

Procedure:

The order of business at a meeting is as follows: The presiding officer calls the meeting to order by striking the table with the gavel and saying, "The meeting will please come to order." A quorum must be present before any business can be legally transacted. (A quorum is the least number of members who are permitted to transact business. This number should be stated in the constitution.)

The minutes of the last regular meeting, and of any meetings which have been held since, should be read by the secretary. The minutes of one meeting should be approved before those of the next meeting are read. The minutes should contain the name of the organisation, the kind of meeting, the place of meeting, the date and hour of meeting, the name of the presiding officer, the approximate number present, the motions stated and how they were disposed of, the manner of adjournment, and the signature of the secretary.

Communications from the president come after the minutes. The presiding officer, who is not at liberty to make or discuss a motion, may now present to the meeting his ideas or wishes. His communication should be written and he should read it standing, but without giving up his place as presiding officer. If the president has taken action for the society since the last meeting, this is also the time to report his action and state his reasons.

The report of the treasurer and the reports of the other officers follow. The treasurer's report should be a statement of receipts and disbursements. It should be disposed of by a motion that it be accepted and placed on file; or accepted and entered in the minutes; or that it should be referred to an auditor.

The reports of committees come next in order. The presiding officer calls on the standing committees to report in the order in which they were appointed. Each committee may have more than one report to give, but each report should be disposed of before another is read. Then the reports of the special committees are heard in the same way.

Unfinished business follows, which includes any motions which were cut off by adjournment, or by expiration of time, or which have been postponed until this meeting.

Miscellaneous business comes next in order; that is, the introduction and transaction of business which has not been brought up before this time.

The meeting closes with an announcement by the president that the meeting stands adjourned, or a motion to adjourn may be made, seconded, and voted upon.

(Continued next month)

The Florence Nightingale Association of Toronto

By JEAN I. GUNN, Superintendent of Nurses, Toronto General Hospital.

A review of the history of the Florence Nightingale Association may be of interest, especially as it is now to be disbanded. The many activities and responsibilities of the Association have gradually decreased, due to the changes in other nursing organisations, until the members felt that the wisest plan was to discontinue as a separate association. It is of interest to note that the Association came into existence when very much needed and discontinued when those many needs had been met in other ways.

The Central Registry for Nurses, which was and still is the only professional registry in Toronto, was organised in 1900 and was managed by a council to which each alumnae association of the local schools for nurses appointed two representatives. Nurses who were not graduates of schools for nurses in Toronto were not represented on the council. In addition to this difficulty, there was the difficulty of membership in the Graduate Nurses Association of Ontario, and the Canadian Nurses Association. Individual membership was not possible in these two organisations and all members were required to belong to a federated association.

The Florence Nightingale Association was organised on March 11, 1910, in an effort to provide a means by which nurses living in Toronto, but not graduates of any local school for nurses, could participate in the activities of their profession.

The presidents since organisation have been: Miss Kennedy, 1910; Miss McKenzie, 1911-1914; Miss Pringle, 1914-1916; Miss Didsbury, 1916; Miss Annie Kinder, 1917-1918; Miss Eunice Dyke, 1919-1920; Miss Jean I. Gunn, 1920-1922; Miss Laura Holland, 1923; Miss Barbara Blackstock, 1924-1925; Mrs. Bowman, 1926; Miss Barbara Ross, 1927-1928; Miss Gridley, 1929; Miss Hutchison, 1930.

The first secretary was Miss Jean Wardell, who served the organisation from 1910 until 1919. The other secretaries were: Miss Locke, 1919-1922; Miss Cowan, 1923; Miss Gridley, 1924-1927; Miss Carroll, 1928-1929; Miss Colborne, 1930.

When an association disbands it is a fitting time to check up its accomplishments, and this Association has to its credit many that are decidedly outstanding. Possibly the greatest of them was the provision of a professional association through which nurses from schools for nurses located outside the city of Toronto could take part in the nursing development and activities of the local registry, the Graduate Nurses Association of Ontario, and the Canadian Nurses Association.

The financial undertakings of the Canadian Nurses Association have always been well supported, this Association contributing its full share toward the purchasing of *The Canadian Nurse* in 1917, the erection of the Nurses' Memorial in Ottawa in 1926, and the financing of the Congress of the International Council of Nurses in 1929. The Association has always taken a very definite interest in community welfare and has contributed towards the finances of local welfare organisations, the Red Cross Society and special appeals.

The members will look back with pleasure and appreciation to the profitable meetings when they were addressed by well qualified speakers on current events and professional affairs. In this way the Association has provided a definite contribution to its members from an educational standpoint. But, even more acceptable has been the opportunities offered for social intercourse, especially to the new member who had not yet formed nursing associations or made friends among the members of her profession.

Changes occur in nursing as in all professions, and the many changes in the past ten years have had a direct effect on the activities of the Florence Nightingale Association. Renovations in the Constitution of the Central Registry of Toronto, in the plan of membership of the Registered Nurses Association of Ontario, and in the Canadian Nurses Association, gradually changed the responsibilities of this Association until practically the only reason for continuing was to provide a means of social intercourse. In these busy days and changing conditions the members felt that the Florence Nightingale Association of Toronto had served the purpose for which it was organised and so could quite honourably fade into nursing history. In the minutes of the first meeting it is recorded that "a spirit of enthusiasm was apparent." This spirit was maintained throughout the twenty-one years of its existence, and we hope will be carried by its members to the other nursing organisations to which they will henceforth owe allegiance.

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New Nurses' Home for City Hospital, Saskatoon

On the afternoon of February 12th the new nurses' home of the Saskatoon City Hospital was thrown open to the public for inspection.

For many years facilities in the City Hospital for both housing and instruction have not been of the best, and although the new home will not at once eliminate all these difficulties, conditions will be greatly improved. The hospital board will now be relieved of the necessity of finding rooms for the staff, for the new home at the present time will house about forty nurses, while sixty will remain in the old building.

The building, which is so constructed as to allow of additional floors being added as finances permit, at present consists of one floor and a full-sized basement, but these two have been used to great advantage.

A neat entrance hall leads after a few steps, to the main floor. Here one enters the reception room, which is small but inviting. To the right is the nurses' room. Although this room appears rather small, it is very bright and cheerful, and tastefully furnished.

Next come the rooms that in the future will be used as supervisors' rooms, but which at present serve as sleeping quarters for the nurses. Two nurses share each room, in which are two beds, a desk, dresser, and two roomy closets.

At the north-east corner is the matron's suite, consisting of three charming rooms.

To the left of the entrance is the business office, and a succession of bedrooms, including the suite of the housemother.

A most up-to-date feature is the incinerator—one of the latest ideas in homes. With this system, all refuse can be thrown direct to the furnace.

In the basement is a study, and the long-needed hospital library. Then, too, there is the fully equipped modern laundry; a dietetic laboratory; a bacteriological and a science laboratory; all the latest of their kind in Canada. It is expected that they will do much to eliminate the difficulties hitherto experienced in the teaching of student nurses. It is expected, too, that the fine lecture room will play an important part in the developing of the student nurse.

The room of greatest interest perhaps is that devoted to a model ward. This model, which is used for demonstration purposes in the teaching of students, contains several beds, and is a complete counterpart of a hospital ward. Everything which can be found in an up-to-date, well-ordered hospital can be found here. In this room, also, all social functions will be held, and the room is one of the finest in the city for the holding of socials or moderately sized dances.

The beauty and utility of this building makes it one of the finest institutions in the city of Saskatoon, and the nurses of the City Hospital may well be proud of their new home, which, it is hoped, will some day be connected by subway to the main hospital.

My Ideal Nurse

My ideal nurse is one who has four great links in the chain of nursing—religion, ethics, theory, and practice. One of the links, poorly prepared, tends to make all imperfect. She is the one who puts forward her best each day, counting that day lost in which there has not been repeated some benefit both for herself and for those around her who are suffering.

"Loyalty" she must always have, be it in a mansion or beside an orphan's cot; "true womanhood" she must show even under the constant criticism of those who, by her good example, may be drawn into the ranks.

These she must ever bear in mind that she may be true to God, to her womanhood, and to her ideal of nursing.

A. T.

Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,
Miss ANNIE LAWRIE, Royal Alexandra Hospital, Edmonton, Alta.

Case Study in Paediatrics

By MARION L. ROBINSON, Student Nurse, Children's Memorial Hospital, Montreal, P.Q.

Baby L.—Age, seven months.

Diagnosis — Acute indigestion, otitis media, mastoiditis.

Social History

Baby L., an only child of French-Canadian parents, was for some unknown reason, staying at a baby farm. The father is a farmer. Both parents are twenty-five years of age, and on visiting the ward appear fairly intelligent and very neat and clean.

The baby farm is reported to be clean and tidy. The children are supposed to play in the park across the street. However, there are numerous "Keep off the Grass" signs in this park, and there is a keeper who watches it all day so that the children are not out of their own tiny yard at the front of the house.

Mr. L. paid $20.00 a month for the baby's board.

This woman had run a similar home before, but the authorities had made her close it because the children were not properly cared for.

Medical History

Baby L. was admitted to the infant ward on September 4th, with complaints of vomiting, diarrhoea, anorexia, and lose of weight, cough and cold. Up to this time he had never been ill. He had been on a diet of eight ounces of milk with sugar, water given between meals, and had started to take cream of wheat. On admission to the ward he was given an intraperitoneal of 250 cc. of Hartmann's solution for dehydration and was put on a diet of lactic acid protein milk, eight ounces, and given six feedings per day, every four hours. He was also given acidosis mixture between feedings to prevent acidosis and to add fluid to the body. The baby had numerous green, watery stools. The white blood count was 20,000 per cu. mm.

His feeding was increased. He was given mist. stramonium, drams one, every four hours for cough, with fairly good results. A paracentesis was done on both ears to try to determine the cause of the high remittent temperature, ranging from 102 degrees F. to 106 degrees F., which the baby had been running. Both ears discharged profusely (discharge purulent). The child was very toxic and irritable. His ears were irrigated with boracic solution every four hours and alcohol drops were instilled.

On September 13th, he was taken to the operating room for simple mastoidectomy, both ears. He was given morphine, gr. 1/24. On return to the ward his condition was poor, pulse rapid, he was cyanosed with tremors of tongue and lower jaw, and the pupils of his eyes were contracted. This condition was diagnosed as acute morphine poisoning. He was given an intraperitoneal of 275 cc. of Hartmann's solution immediately, and in the evening a blood transfusion of 120 cc. At night he was given a sedative for restlessness, with poor results.

On the following day his feeding was changed to lactic acid protein milk, twenty-eight ounces; corn syrup, 50%, two ounces: six feedings of five ounces, which he took poorly. On September 19th his feeding was again changed to reinforced protein milk, and this he took better. On the following day he was given reinforced protein milk, twenty-eight ounces;

corn syrup, 50%, two ounces. He took this very poorly, and during all this time he continued to have green, watery stools and lost weight.

On September 20th his feeding was changed to whole boiled milk, twenty ounces; water, eight ounces; corn syrup, 50%, two ounces; three teaspoons lemon juice. At this time he began to refuse all feedings and his cough was very troublesome. On September 24th he was gavaged and this was continued for all feedings until October 3rd. He was given two intraperitoneals, one of 125 cc. and one of 400 cc. Hartmann's solution, also five interstitials of 125 cc. Hartmann's solution for dehydration. His mastoid dressing was changed every second day, and both had a sanguineous, purulent discharge. At this time he was given 100 cc. citrated blood intraperitoneally. Special attention was given to his back and buttocks to prevent the skin from breaking down. The baby was kept on his side as much as possible and back rubbed with alcohol and powder. Buttock paste was applied to buttocks each time diaper was changed. As baby's condition began to improve he was given one ounce of orange juice and ten drops of cod liver oil twice a day.

Complications

The ear condition was no doubt a complication. However, it may have caused the diarrhoea and high fever.

The child's idiosyncrasy to morphine, which caused the morphine poisoning, was also a complication.

Prognosis

The prognosis is good, providing the child is kept on a proper diet.

Nursing Care

The baby is given a bed bath every morning and his back rubbed with alcohol and powder. His buttocks are covered with an application of buttock paste to keep the skin from breaking down. The diapers are changed frequently, to keep baby clean and dry; this also helps to keep the skin in good condition and keeps him from being so restless. He is turned often from side to side. The buttock paste is made from equal parts of vaseline, zinc ointment, cold cream, and enough balsam of peru to give it a brown colour. It has great healing powers, and if properly applied will relieve and prevent any redness or soreness.

Diet

In addition to that mentioned above, on October 6th his feeding was changed to barley water, twenty ounces; sweetened condensed milk, two ounces: seven feedings of three ounces.

On October 11th he was given evaporated milk, fifteen ounces; water, fifteen ounces; corn syrup, three ounces: five feedings of five ounces.

On October 14th he was given cream of wheat with same formula, and on October 18th soup was added to diet.

On October 28th, evaporated milk, fifteen ounces; water, fifteen ounces; boiled milk, five ounces; corn syrup, three ounces; cream of wheat, five tablespoons; Ferri Catalytic, one teaspoon, in formula.

The feedings were changed to try and find a feeding which would be easily assimilated and meet the body requirements.

Convalescence

As the baby began to improve, I noticed him trying to raise his head to watch those around him, so the head of the bed was elevated and he was quiet and happy for hours during the day, watching us at our work. He also was given a rattle, which proved a great delight to him and which helped to stop many crying spells.

Problems Met With

1. His refusal to take any feeding by nipple, pippette or spoon.
2. Irritability.

What I Learned From a Study of This Case

1. The different feedings given for such a case.
2. Different methods of feeding an infant.
3. Experience in giving interstitials and the effect obtained from them.
4. The symptoms of morphine poisoning.

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,
Miss CLARA BROWN, 153 Bedford Road, Toronto, Ont.

Private Duty Nursing Experience as an Asset in Private Health Nursing

By MARY MATHEWSON, University Library, University of Toronto

We are living in an age when world conditions seem to "change visibly before our very eyes." The situation in the field of private duty nursing cannot be attributed alone to the present world wide depression. Community conditions have been changing rapidly with the development of industry and the growth of large cities. The resultant overcrowding, poor housing, unemployment and lowered earning power have added to the burden of sickness and ill health.

It is estimated that two per cent. of the population is sick all the time. Only fifteen per cent. of those who are ill are able to provide for private nursing care and yet approximately sixty per cent. of graduate nurses are engaged in this branch of the work. Nevertheless, the other eighty-five per cent do have critical illnesses and really need the care of a graduate nurse although they are unable to meet the expense. It is equally certain that the private duty nurse is only making a bare living at best and cannot afford to reduce her fees. Some other system must be evolved, for the situation is serious for the general public as well as the nurse.

In recent years, a great deal has been learned concerning the prevention of disease and the improvement of health. Epidemics are fortunately rare and the duration of sickness has been shortened in many cases. The infant mortality rate has been substantially reduced. In spite of these facts, twenty per cent. of present illness is said to be preventable. This certainly should not be the case with the fund of scientific knowledge at our disposal. The problem is to assure the understanding and every day practice of this newer scientific medicine by the masses.

A mother does not know by intuition how to care for her baby, but must be taught, and certainly the neighbour who "knows all about babies because she has buried six" is not the best teacher.

The graduate nurse is the logical person for this task. Already at work in this great field of preventive medicine and positive health are groups of graduate nurses called public health nurses, but they are still far too few in number.

Public health nursing does not mean only bedside care for the sick poor as so many people, even doctors and nurses, I am sorry to say, imagine. It covers a much broader field, and has for its aims the care of the sick, the prevention of disease and the promotion of health. The public health nurse deals with individuals from infancy to old age through pre-natal clinics, infant and pre-school work, school and industrial nursing, tuberculosis and mental hygiene service as well as bedside care of the sick in their own homes.

It would seem within the bounds of possibility that eventually nursing care and health education may be available for all through some form of health insurance. Whatever scheme is developed to meet the situation, the public health nursing services must be developed to fill the need. Consequently, there will be golden opportunities for those who are prepared. Do not let us wait, like

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(Read at the annual meeting of the Association of Registered Nurses of P.Q., Montreal, Private Duty Section.)

Micawber, for something to turn up. Now is the time to take stock of ourselves and make plans for the future.

Of what value will our private duty experience be to us in this new scheme of things?

After all, good nursing is the same at all times and in all places; it must just be adapted to circumstances. The actual nursing care of a patient is the same by the public health nurse as by the private duty nurse, except that in the poorer home there are fewer conveniences with which to work. There is need for greater ingenuity and less time can be spent with each patient. To those accustomed to working in hospitals and comfortable homes it is a revelation that so much can be done to make a patient comfortable in a poor home with the means at hand. With clean newspaper (which may be used for everything from wastepaper baskets to rubber sheeting), a kitchen chair for a back rest and a suitcase or even a bureau drawer for a baby's bed, miracles can be performed.

The private duty nurse already has scientific knowledge and professional skill. Her outlook has been broadened by contact with many individuals and many homes. She has worked with many physicians. She has learned to think and act quickly and surely in emergencies. She has seen the patient return to health away from the unnatural restraint of the hospital and has helped in the readjustments necessary after a long illness. She has learned to observe without appearing to observe and to adapt herself to her surroundings.

These qualifications certainly are decided assets upon which to build a successful public health nursing career. Let us face the fact that present hospital training without supplementary study does not fit one for satisfactory public health nursing. The very nature of our training schools makes it inevitable that the emphasis is laid on the sick, or abnormal rather than the normal. A public health nurse is essentially a health teacher. She must know her subject and how to teach it. She must get below the surface of effects to find causes. Do nurses know health? Do we know what a person who enjoys the optimism of health is like? Certainly this is not the type of person met in the hospital wards.

The first requisite then, is to know what actually constitutes health, the rules for maintaining health, what happens when these rules are broken, the signs of incipient disease and the ability to so enthuse others that they will adopt our point of view as their own. At first it may seem incredible that a nurse going into a home, ostensibly to give nursing care to a mother with pneumonia, will discover in one visit that there are two bedrooms in that home without windows, that the children are all undernourished and potential tuberculosis subjects, that the family diet is largely bread, pie and coffee and that the twelve-year-old daughter is being taxed beyond her strength in her effort to care for her mother as well as the other children.

Certainly no novice could note all these facts nor have the knowledge and tact to start active relief measures at once. The nurse who has no knowledge of preventive medicine could probably care for the mother, but it is very likely that she would not even realise the other equally important points, nor would she know how to cope with them.

Training for this work may be obtained at a university giving a post graduate course or if this is impossible, through carefully supervised experience as a staff nurse. Even a few months of such experience can give an entirely new point of view. The inexperienced nurse who attempts to work alone without supervision will, at best, gain her experience at the cost of valuable time and many mistakes. She will probably never even realise the opportunities which are knocking at her very door.

The nurse who goes into public health nursing because the hours are short or the evenings are free is seldom successful enough to satisfy either herself or her superiors. For the right nurse who is truly interested the opportunities and satisfaction found in the work are unbounded.

Nursing is so closely bound up with the very necessities of life itself that it must change with changing years. The systems and methods of today may pass but the leaders of our profession will be equal to the task of evolving new systems which will be better fitted to meet the conditions of the future. There will be "newer and wider channels of usefulness, better care for the sick, better protection for the well, and lastly, better and more hopeful lives for the nurses themselves." Let us not be found unprepared.

The Night Nurses' Sleep

Many night nurses find it extremely difficult to sleep in the day-time, especially during the summer months, when it is often hot and there is no darkness till nine or ten o'clock. Almost by instinct, sleep comes most easily with the darkness, and it is difficult for some people to reverse the natural sequence of sleeping and waking. Yet it is a great factor in both the nurse's health and her patients' well-being that she should go on night duty fresh and rested. There are several methods of inducing sleep, but one that has proved invaluable and yet remains almost unknown is to cover the eyes with a bandage of black velvet folded double. This at once makes perfect darkness and leaves the sleeper free to have her windows open and her blinds up, allowing of an abundance of fresh air—a most important point. The already tired mind, unconscious even of a flood of sunshine in the room, is satisfied with the artificial suggestion of night, and sleep follows as a natural consequence.

Several sleep-inducers are at the same time harmless, delightful and very efficient. One or two raw lettuce leaves eaten just before settling down will often work wonders. Tilleul tea, made by infusing a few lime blossoms in a china tea-pot and drunk either sweetened or plain is a French remedy for sleeplessness. A drink of orange water is another useful means of getting to sleep.

A sagging mattress is often a cause of wakefulness, because the spine is distorted and this sets up a general irritation of the whole nervous system. Blocking the head of the bed is a device worth knowing, for it drives the blood away from the head and so dulls the activities of the brain. Very light covering and a warm bottle to the feet (even in hot weather, provided that the covering is particularly light) will aid this even further.

When sleep seems unusually far away, it is a good plan to start going to bed all over again: a warm bath, a freshly made bed, a soothing drink, a spray of eau de Cologne, light massage to the abdomen. It is well worth doing, even in the middle of the afternoon.

It is well to remember that sleep, like most other things, is largely a matter of habit. Therefore, no stone should be left unturned by the night nurse to ensure making a good start. One good day's sleep paves the way for another, and the habit of sleeping well in the daytime begins surely and soundly to form. Resorting to drugs, however mild, is not a good thing to do. The best of them do not encourage natural sleep—in fact, they tend actually to break the habit; for only so long as their action lasts is the mind really at rest; and another thing, which is very often ignored, most of them are diaphoretic in action, which, as all nurses know, is not a good thing to induce in excess in the normal healthy state.
—Marguerite Cecilton, in Nursing Times.

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,
MARY F. CAMPBELL, 344 Gottingen Street, Halifax, N.S.

Then and Now

By M. A. TWIDDY, Penticton, B.C.

When I graduated as a public health nurse I had many definite ideas about "how I would organise in a new district." First, I would have a good-sized photograph on the front page of the local paper, at least a month before I was scheduled to arrive, with the announcement of such arrival, all my credentials, etc., published. I had visions of closing hospitals and seeing all the people living a strictly hygienic life. All children would drink milk, eat lettuce, and be in bed at eight every night. As a result of my public health programme, there would be no cancers, tuberculosis, or infectious diseases in the district. All this, and even more, was to be quite fully accomplished in at least four or five years. These visions came in spite of being warned in classes that we must expect the work to move slowly, etc.: but *I* would make things hum when I started a district of my own. I would get school work well established; hold a baby clinic each week, with all the babies in town attending; have a monthly T.B. clinic; be in every home and know every man, woman and child by their first name within a year.

So much for untried theories—as for something practical, that is another story.

When I arrived in the district I found that many had not seen the paper containing my advance notice, and had never heard of me. "A public health nurse, what does she do anyway?"

After much explaining for a few months to small groups and in homes, people began to know me, and something of the work I was trying to do. I soon found out that great distances, weather, and many other factors would prevent me from having baby clinics for some time, in fact, I was in one district three years before I even had a weighing station running properly. I had for a long time to be content with seeing a few babies in the homes. There was no doctor to take charge of the T.B. clinic so that plan had to be abandoned for the time being. Many people could not afford to pay the doctor and dentist, so correction of defects in children had to be delayed. So one works on for months, amidst this delay and that, and finally must feel resigned to report about one-third of the originally planned work accomplished.

Experience is a good teacher. It may be an expensive and slow method of obtaining knowledge, but one learns many interesting lessons as a public health nurse. It is surprising from whom, and under what circumstances, these lessons come, in the school of experience. Day after day, and week after week, knowledge accumulates. Wisdom may linger when it comes to making use of the lessons, but if the public health nurse maintains her sense of humour she will have gone far towards success. She must never mind disappointments, but look for the silver linings that are always to be found somewhere, firm in her conviction that eventually will dawn that day so well described by Alfred, Lord Tennyson:

> "All diseases quenched by Science, no man halt, or deaf, or blind;
> Stronger ever born of weaker, lustier body, larger mind."

Perhaps I have allowed the pendulum to swing too far the other way, and am now content with too little, but I do believe that I have at last really learned that "Rome was not built in a day."

News Notes

ALBERTA

Calgary: The annual dance of the Calgary Graduate Nurses Association, held in Penley's Hall, February 10th, was one of the most successful ever held by the organisation. The guests were received by Mrs. Stuart-Brown, Miss Ashe, Miss I. Jackson, and Miss A. Casey.

Miss Margaret J. Kerr is taking a post-graduate course in New York City.

Edmonton: The regular meeting of the Edmonton Association of Graduate Nurses was held on February 18th in the Y.W.C.A. parlors. Twenty-eight members were present. Miss K. Connor, of the Normal School staff, was the speaker, giving the nurses an outline of methods used in teaching health and prevention of disease.

Miss Olive Grant, Provincial Public Health Nurse, is in charge of the recently organised Infant Welfare Centre at Stanmore, Alta. Miss Hazel K. Brunker has returned from Honolulu, and is spending the winter with her mother at Wainwright, Alta. Miss Lois Humber has gone to Trail, B.C. Miss Amy Conroy, lecturer, attached to the Public Health Nursing staff of the Provincial Department of Health, has commenced her home nursing lecture itinerary for the year. There are eighty-one centres to be visited, extending from the Peace River in the north to the boundary on the south. Miss Conroy lectured to 4,750 women last year, and she hopes to welcome many newcomers this year.

During the winter season at the Agricultural Colleges throughout the Province Miss Elizabeth Davidson, Miss Rowena Elves and Miss Ethel Jones acted as instructors in health education.

Royal Alexandra Hospital: One of the first festivities in honor of the 1931 graduating class was a Valentine Dance given in the Nurses Home of the Royal Alexandra Hospital, by the Intermediate Class, on Tuesday evening. The decorations were carried out with true Valentine spirit—Cupid and his darts, as well as hearts large and small, were everywhere.

During the evening, Miss Marion Joslin, on behalf of the Intermediates, presented each member of the 1931 class with a lovely little hypodermic set, as a token of their esteem and affection. Assisting in the receiving of the guests were Mrs. A. F. Anderson and Miss Margaret Cameron with Miss Annie Lawrie.

Miss Laufey Einarson, Class 1929, is taking post graduate work at McGill University, Montreal.

Miss Helen Booth, Class 1929, left in February for Montreal to take a Public Health Course at McGill.

Miss Ethel Brown, Class 1926, has accepted a position on the staff of the Municipal Hospital at Pouce Coupe, B.C.

Miss Lois Humber is leaving shortly for her new position in the Hospital at Trail, B.C.

BRITISH COLUMBIA

The following list gives standing in order of merit of nurses writing the recent examination for the title and certificate of Registered Nurse of British Columbia:

First Class—80% and over: Misses I. M. Collier, Vancouver General Hospital; E. Buckham, Vancouver General Hospital.

Second Class—65% to 80%: Misses M. J. Burry, A. E. Newcombe (G. E. Minhinnick, R. Townsend, equal), M. C. Green (W. F. B. Emery, E. W. Heys, equal), F. A. Garthorne, P. Gooding, S. I. Seldon, C. L. Fox (H. E. Duffield, D. A. Hargreaves, equal), A. F. Smith, H. D. Hocking, R. Kirkendale, K. E. Richmond, L. M. Parker (T. Birtley, E. M. L. Harman, D. T. Laurance, equal), V. M. Dyer (H. M. Apps, D. M. Finch, equal), A. M. Simser (V. P. Denike, M. J. Dickson, equal), W. M. Parker, A. McCarthy, E. D. Maitland, E. M. Hardy (M. L. Sutherland, C. M. Frith, K. A. Seaman, equal).

Passed—50% to 65%: Misses E. F. Crichton, E. I. Cole, C. W. Boyd, G. R. Price, M. A. McMahon (H. M. Annis, M. F. Guild, equal), N. Alleyn, J. Murray, M. C. Webb (S. M. Keeler, A. S. North, equal), E. M. Smith, M. Whitehouse, M. G. Gould (M. E. Campbell, M. E. Little, equal), C. McCreight (M. A. Dixon, M. K. Oatway, equal).

Passed with Supplemental: Miss M. S. Wankling.

Vancouver: The regular monthly meeting of the Vancouver Graduate Nurses Association was held on the evening of February 11th, in the Chemistry Building of the Vancouver General Hospital; routine business occupied the greater part of the time. The Ways and Means Committee announced that the sale of tickets in a drawing for a Ford sedan car was under way. The committee hopes to sell about 5,000 tickets at fifty cents each. Any surplus is to be used for the General Hospital Alumnae Association's Sick Benefit Fund, and it is hoped that in this way a large contribution can be made. Following the disposal of the business, the meeting adjourned to the Auditorium as guests of the Board of Directors of the hospital, for refreshments.

Victoria: The annual meeting of the Victoria Graduate Nurses Association was held at the Nurses Home, Royal Jubilee Hospital, on February 4th, 1931.

The following officers were elected for the ensuing year: President, Miss Edith Franks; First Vice-President, Miss Meta Hodge; Second Vice-President, Miss Harriet O'Brien; Secretary, Miss Stella Herbert; Treasurer, Miss Winnifred Cooke; Councillors, Misses Ethel Morrison, Helen Cruikshanks, E. Kenney, Frances Hook, Ellen Cameron.

After the routine business was concluded, a very pleasant social hour was spent in the reception room, where refreshments were served. The pupil nurses very graciously supplied the entertainment for the evening, giving an excellent programme of musical numbers and readings.

On February 14th, Miss L. Mitchell, Superintendent of Nurses, Royal Provincial Jubilee Hospital, entertained the new executive of the association at a bridge tea, given in honor of Mrs. Phyllis Kirkness, the retiring secretary. After an hour spent playing bridge, tea was served in front of the fire in the spacious reception room of the nurses home. The table was centred with a bowl of daffodils.

MANITOBA

St. Boniface Hospital: The Alumnae monthly meeting was held at the Nurses Home, St. Boniface Hospital, on March 11th, with Miss Shirley, President, in the chair. Reverend Father D'Eschambault was the speaker of the evening, and gave a very interesting talk on the early history of the French settlers of the north west. The third year students were the guests of the Alumnae, and at the conclusion of the meeting a social hour was enjoyed, Miss Dorothy McGavin and Miss M. Anderson, student nurses, adding to the pleasure of the evening with several musical numbers.

The Alumnae held a successful silver tea recently, at the home of Mrs. (Dr.) J. Picard. Miss H. Miller (1931), has made a successful recovery after a recent illness. Miss Emma Kuneman (1929), has accepted a position as staff nurse in St. Anthony's Hospital, The Pas, Man.

NEW BRUNSWICK

Hotel Dieu Hospital, Chatham: On the evening of February 10th, the student nurses spent a very pleasant hour in company with several members of the Alumnae. A short but interesting programme, consisting of essays and readings was given by the students. An enjoyable and very sharply contested debate was also held by the class, the subject argued being, "That diets are more potent in the cure and prevention of disease than are drugs." In giving the decision of the judges, the chairman, Rev. Father Ryan, stated that though the problem of deciding the winning side proved a perplexing one, for obvious reasons the final vote was given in favour of the affirmative. Besides the members of the nursing staff and the Alumnae, there were present: Reverend Fathers Crumley, Ryan and Williams, Doctor A. J. Losier, and Mr. B. Irving. With the exception of Dr. Losier, who was called away during the entertainment, these gentlemen acted as judges in the debate.

At the end of the programme, a very dainty luncheon was served by the Sisters on the nursing staff.

Saint John: The Saint John Chapter of the Registered Nurses Association at its meeting of February 23rd, held at the nurses home of the Saint John Tuberculosis Hospital, was addressed by Dr. R. J. Collins, superintendent of the hospital, who, with the assistance of Dr. Busby, showed motion pictures to illustrate methods of early detection and diagnosis of tuberculosis, and gave a demonstration of pneumothorax treatments. Miss E. J. Mitchell was in the chair, and the meeting was well attended.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in March, 1931, were 1,111, seventy-four less than in February, 1931.

Appointments

Adeline Mae Hammill (Grace Hospital, Toronto, 1930), to night supervisor at the Plummer Memorial Public Hospital, Sault Ste. Marie, Ont. Robena Buchanan (Oshawa General Hospital, 1926), to night supervisor, Queen Victoria Memorial Hospital, North Bay, Ont.

Misses I. Mick, O. Gerker, and M. Colster to floor duty nursing, the new pavilion, Toronto General Hospital. Misses A. Watt and M. Kyles to the staff of the Riverdale Hospital, Toronto.

District 1

Hotel Dieu Hospital, Windsor: Miss Alice Arnold, well-known and much beloved private duty nurse of Windsor, and a graduate of the Hotel Dieu Alumnae, passed away suddenly a few moments after coming off duty on January 20th, 1931. Miss Arnold had done private duty work in Windsor ever since her graduation in 1921, and will be greatly missed by all who knew her for her cheerfulness of spirit and untiring effort. Her sudden death was a shock to all her friends. Miss Arnold held many offices in her Alumnae Association, and was councillor for District No. 1 when it was first organised. The funeral was held from her father's home in Chatham, Ontario. and was attended by a number of nurses from the Hotel Dieu acting as a guard of honour. Among the numerous tokens of sympathy was one from the Sisters of Hotel Dieu in whose esteem Miss Arnold was held most highly.

District 2

A meeting of District No. 2 Registered Nurses' Association of Ontario was held on February 9th, at Woodstock. Representatives were present from Paris, Owen Sound, Simcoe, Galt, Ingersoll, Brantford, and Woodstock. An attractive programme was arranged. Dr. Krupp gave a very splendid illustrated address on China, Korea and Ceylon, following an address by Miss Leona Armstrong, a missionary with the United Church who is home on furlough from Korea. Dr. Ballantyne brought greetings from the Medical Society of Woodstock to the meeting. Dr. Tennant, of the Mental Hospital, Woodstock, who was to have given an address on the choice of nurses for mental hygiene work, was unfortunately called out of town. A report of the Membership Committee was presented by Miss Muriel Nichol, Convener. Miss Hilda Muir spoke on the progress of the Nurses Education Fund Committee; Miss Jessie Wilson presented the report of the Nominating Committee for officers for the Association. Miss E. M. McKee was appointed convener of Publications Committee. The delegates were entertained at a very delightful luncheon at the Woodstock General Hospital. They were welcomed by Miss Helen Potts, Superintendent, and the nurses of the Alumnae Association of the Woodstock General Hospital.

GENERAL HOSPITAL, BRANTFORD: The Alumnae held a very interesting meeting on January 3rd, when Dr. C. C. Alexander gave an instructive talk on tuberculosis. An important item of business transacted was the formation of a Private Duty Council to be elected each year to deal with private duty problems of those nurses on the Registry conducted by the Alumnae of the hospital.

Mrs. F. McLean (Edna Clark), of Brampton, was a recent visitor to the Brantford General Hospital.

GENERAL HOSPITAL, GUELPH: Miss K. McRae, C.P.H.N., London, 1930, is doing school nursing in Renfrew. Misses Ethel Eby and S. Scales are taking a course in public health nursing at Western University, London, Ont. Miss J. Pierson is at Royal Victoria Hospital, Montreal, taking post graduate work in obstetrics and surgery. Miss Marion Wood recently completed a post-graduate course in surgery at Toronto Western Hospital. Miss Alice M. Plowright sailed for England late in January and will in future make her home in London. Miss M. Singer is spending the winter in California, and Miss E. Dennis in Florida. Miss Isabel Henderson will spend the next several weeks touring Scotland. Miss L. Featherstone has resigned her position as supervisor of Harper Hospital, Detroit, Mich., to take post-graduate work in Women's Hospital, New York City.

The Alumnae Association is donating a desk-set for the doctors' sitting room in the hospital.

DISTRICT 4

GENERAL HOSPITAL, HAMILTON: Sincere sympathy is extended by the members of the Alumnae to Miss Annie Boyd (President), and Miss Daisy Boyd on the death of their mother.

DISTRICT 5

TORONTO: The February meeting of the Instructor's Section of the Centralised Lecture Committee for Student Nurses was held in the Nurses Residence of the Orthopedic Hospital. A questionnaire had been prepared previously and sent to each school, and representatives were ready with these, completed.

Each subject of the curriculum was considered—the number of hours of instruction, laboratory work, etc., compared and discussed. In this way, much interesting information was interchanged.

Case histories—their educational value, was introduced by Miss Strachan and discussed by the group, the general opinion being that these are of value as a method in assisting the student to consider the patient as an individual, to increase her powers of observation, to become familiar with text and reference books, and to understand the reasons for various treatments.

GRACE HOSPITAL, TORONTO: Miss Jean I. C. Anderson (1927), has recently returned to Toronto from Baltimore, Md., where she completed a post-graduate course in surgery and operating-room technique at the Johns Hopkins Hospital.

WESTERN HOSPITAL, TORONTO: The regular meeting of the Alumnae was held on February 10th, and took the form of a social evening at the home of Mrs. F. A. Spence (Jean Bennett, 1916). During the evening bridge was played and a most enjoyable time was spent.

Members of the Alumnae will be sorry to learn of the death of Miss Isabella Riddell (1899), who, after a long illness, passed away in the Toronto Western Hospital on February 23rd. Miss Riddell was a member of the first graduating class of the Toronto Western Hospital. Of the five members who formed that class, Miss Riddell is the only deceased.

DISTRICT 8

OTTAWA: Candlelight, firelight, flowers and small cosy tables conspired to create a delightful atmosphere for the dinner meeting of the Public Health Group of District No. 8, held at the Tyndale Inn, Ottawa, on February 12th. About forty nurses were present, representing the following groups—Ottawa Board of Health Nurses, School Nurses, Industrial Nurses, Provincial Department of Health Nurses, and Victorian Order Nurses.

The speaker for the evening was Dr. Helen MacMurchy, who chose as her subject "The Art of Getting Things Done." This address, grave, humorous and whimsical in turn, was much enjoyed by those present.

Seated at the head table with Dr. MacMurchy were, Miss Gertrude Bennett, Miss Gertrude Garvin, Miss Mabel Stewart, Miss Elizabeth MacGibbon, Miss Frances Lyons, Miss Mary Slinn, Miss Elizabeth Smellie, Miss Dell MacGregor and Miss Dorothy Percy, Chairman of the Public Health Group. As the meeting was an annual one, a report of the activities of the Group since organisation in March, 1930, was given by Miss MacGibbon, Secretary-Treasurer; and the following officers were elected for the ensuing year: Chairman, Miss Marjorie Robertson; Vice-Chairman, Miss Alison Dickison; Secretary-Treasurer, Miss Elizabeth MacGibbon.

QUEBEC

MONTREAL: At the annual meeting of the Montreal Graduate Nurses Association, held on January 13th, in the Club Hall, a motion was passed to the effect that four outstanding members of the Association, Miss E. Baikie, Past President; Miss Helen Des Brisay, Past President; Miss Annie Colquhoun, Past President; and Miss Helen Hill, a Charter Member, be made Honorary Members of the Association.

General Hospital, Montreal: Miss Charland (1927), has taken a position with the Toilet Laundry Company. Miss D. Mignot (1930), has joined the Montreal V.O.N. Miss Lottie Urquhart (1913), is relieving at The Royal Edward Institute.

School for Graduate Nurses, McGill University, Montreal: Miss Dorothy McCarogher (1927), who resigned her position with the Child Welfare Association, Montreal, last June, spent four months in London, England, taking a short course in dentistry and anesthetics in preparation for work in Africa, leaving London in January to take up missionary work under "The University Mission" in Central Africa, arriving in Zanzibar early in February.

Miss Reita Brooks (1930), is doing school nursing in Timmins, Ont. Miss Marjory Fleming (1930), is in charge of the Child Welfare Department, Victorian Order of Nurses, Calgary, Alta. Miss Anna May (1930), is on the staff of the Henry Street Settlement, New York City. Miss Marian Mercer (1930), with the Victorian Order of Nurses, Brampton, Ont. Miss Emily Groenwald (1930), instructor, Guelph General Hospital, Guelph, Ont. Miss Edith Ames (1930), instructor, Saskatoon City Hospital, Saskatoon, Sask. Miss La Verne Leach (1930), night supervisor, Alexandra Hospital, Montreal. Miss Marjorie Dobie (1927), who is at present at International House, New York, submitted the design which was accepted for the Crest of the Canadian Nurses Association.

A very delightful tea was given by the Montreal nurses of the Alumnae, at the Women's Hospital, to this year's students.

The late Miss Louise Dickson left a bequest of one thousand dollars to the Flora Madeline Shaw Memorial Fund, School for Graduate Nurses, McGill University. Miss Dickson had always taken a great interest in the efforts to raise money for this Fund which is used for two scholarships each year to nurses who wish to attend the School.

The Flora Madeline Shaw Memorial Fund Committee is planning to hold a bridge on April 17th, in the Ritz-Carlton Hotel, Montreal, at which it is hoped a sum sufficient to cover the yearly scholarship will be raised. The Committee will welcome contributions from nurses, and it is hoped that all graduates of the School for Graduate Nurses, McGill University, will lend their aid in the reaching of this objective. Nurses not able to attend the bridge in Montreal are asked to contribute to the Fund in some other way.

SASKATCHEWAN

The Saskatchewan Registered Nurses Annual Convention and Institute will be held in Moose Jaw, April 8th, 9th, and 10th, 1931.

Miss Mary E. Gladwin, of Rochester, Minn., will be the chief speaker. The tentative programme includes three addresses by Miss Gladwin; one by Dr. Goodwin, of Moose Jaw, and others on superannuation for nurses and psychiatric nursing.

C.A.M.C.

Alberta: At the annual meeting of the Overseas Nursing Sisters' Club, Mrs. G. G. Stewart was returned to office as president.

Manitoba: The annual meeting of the Nursing Sisters' Club was held at Deer Lodge Hospital, on the evening of February 25th. The meeting was well attended—Miss McGillvary, President, in the chair. After the reports of the various committees had been received, the election of officers took place, the following members being returned to office: President, Miss S. Pollexfen; Vice-President, Mrs. C. Davidson; Secretary-Treasurer, Miss T. O'Rourke; Social Convener, Mrs. T. Cavanagh; Press and Publicity, Miss N. Shaughnessy; Sick Visiting, Miss E. Bayliss; Memorial, Miss Billyard; Membership, Miss McGillvary. Extra members: Mrs. Morrison, Mrs. McLeod, Miss Dickie. At the close of the meeting refreshments were served by the members of the Deer Lodge Hospital staff.

Long, long corridors, rows and rows of beds; flushed faces, pain-wracked bodies, trays, medicines, baths, thermometers, and so the long day goes on, but,

There's a peak that beckons
A port that calls,
A lake that lures, and a sea that thralls,
And I want to get out of my own four walls,
And beat it away to somewhere!

And why not this summer make the "somewhere" EUROPE, and that with the Sixth All Canadian Party. You'll find details on page 000.

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Apply to:

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BIRTHS, MARRIAGES AND DEATHS

BIRTHS

BARNES—On February 25th, 1931, to Mr. and Mrs. Arthur Barnes (Elinor Davies, Hamilton General Hospital, 1923), of Edmonton, a daughter.

BARNES—In December, 1930, at Yorkton, Sask., to Dr. and Mrs. Leslie Barnes (Mabel Walcott, Toronto Western Hospital, 1920), a daughter.

CHARLEY—On February 13th, 1931, at Edmonton, Alta., to Mr. and Mrs. James Charley (Edith Williams, Pembroke Hospital, Pembroke, Ont., 1914), a daughter.

CRAKE—On February 14th, 1931, at Toronto, to Mr. and Mrs. Cliff Crake (Gladys Elmira Clarke, Grace Hospital, Toronto, 1921), a daughter.

DICKSON—Recently, to Mr. and Mrs. J. Dickson (N. O'Mara, St. Boniface Hospital, St. Boniface, Man., 1925), a daughter.

DUNN—On January 2nd, 1931, at Toronto, to Mr. and Mrs. Cecil Dunn (Grace Hospital, Toronto, 1922), a daughter.

HODGINS—On January 29th, 1931, to Mr. and Mrs. Hodgins (Laura Belle Turrell, Hamilton General Hospital, 1926), a son.

MACDONALD—On March 9th, 1931, to Mr. and Mrs. E. C. MacDonald (Mary Cumberland, Calgary General Hospital, 1920), a son.

MURRAY—On February 16th, 1931, at Miami, Florida, to Mr. and Mrs. A. H. Murray (Flora MacBeath Adams, Soldiers Memorial Hospital, Campbellton, N.B., 1925), a son. Baby died

NARTER—Recently, to Mr. and Mrs. Roy Narter (Aline Vieville, St. Boniface Hospital, St. Boniface, Man., 1924), a son.

NIX—On February 4th, 1931, at Edmonton, Alta., to Dr. and Mrs. H. Nix (Viola Mae Ferguson, Royal Alexandra Hospital, 1927), a son.

POWER—On October 1st, 1930, at Toronto, to Mr. and Mrs. Fred Power (Olive Mary Noble, Grace Hospital, Toronto, 1921), a son.

SARJEANT—On October 3rd, 1930, at Toronto, to Dr. and Mrs. P. A. Sarjeant (Elsie Mary Reid, Grace Hospital, Toronto, 1918), a son.

SMART—On March 2nd, 1931, to Mr. and Mrs. Allan Smart (Doris Lewis, Montreal General Hospital, 1926), a son.

MARRIAGES

BRYANT — MACAULEY — In January, 1931, at Sherbrooke, Que., Ann I. MacAuley, of Gould, P.Q., to Clifford Bryant, Sherbrooke.

COLQUETTE—BURNETT—On February 28th, 1931, at Albany, N.Y., Ina Burnett (Toronto Western Hospital, 1929), to Bruce Colquette.

JACKS—GOODFELLOW—On December 17th, 1930, at Toronto, Ont., Isabel Goodfellow (Hamilton General Hospital, 1930), to Wilfred O. Jacks, of Stroud, Ont.

JOYCE—HENRY—On September 18th, 1930, at Vancouver, B.C., E. Lillian A. Henry (Vancouver General Hospital, 1930), to Stephen L. Joyce, of Powell River, B.C.

KOHLI—CAMERON—On September 7th, 1930, at Meaford, Ont., Annie M. C. Cameron (Grace Hospital, Toronto, 1928), to Frank Kohli, Hespeler, Ont.

KYLE—HESSELL—On January 24th, 1931, Gladys Hessell (Montreal General Hospital, 1928), to V. Kyle.

LANGSDON — EPPLE — Recently, Anne Epple (St. Boniface Hospital, St. Boniface, Man., 1929), to J. Langsdon, Sacramento, Calif.

LAWRENCE—THOMPSON—On February 14th, 1931, at West Shefford, P.Q., Aleida Thompson (Toronto Western Hospital, 1925), to Irving Lawrence, of West Shefford.

MALCOLM—DUCKWORTH—On January 7th, 1931, at Duzdab, S.E. Persia, Hilda Duckworth (Grace Hospital, Toronto, 1927), to George Malcolm, of Duzdab, Persia.

McGREGOR—FLATT—On October 9th, 1930, at Toronto, Myrtle Belle Flatt (Grace Hospital, Toronto, 1927), to Thomas Gerald McGregor, of Toronto.

OLDALE—DAVIS—On August 5th, 1930, at New Westminster, B.C., Jessie M. Davis (Royal Columbian Hospital, New Westminster, 1928), to Thomas J. Oldale, Jr., of Powell River, B.C.

SILVERWOOD — McPHERSON — On February 14th, 1931, at London, Ont., Nora E. McPherson (Hamilton General Hospital, 1913), to Albert E. Silverwood.

VILLENEUVE—McLEOD — On October 20th, 1930, at Ottawa, Aliva McLeod (Ottawa Civic Hospital, 1928), to O. F. Villeneuve, Maxville, Ont.

DEATHS

DUNCAN—On February 21st, 1931, suddenly, at Hamilton, Ont., Jessie Gordon Duncan (Hamilton General Hospital, 1912).

McMULLEN—On February 5th, 1931, at Kingston, Ont., Mrs. David McMullen (Jean Coral Lennan, Toronto Western Hospital, 1916), of Frankford, Ont.

RIDDELL—On February 23rd, 1931, at Toronto, Isabella Riddell (Toronto Western Hospital, 1899).

ROSS—On January 20th, 1931, at Buffalo, N.Y., Amelia Hull Ross (Grace Hospital, Toronto, 1918).

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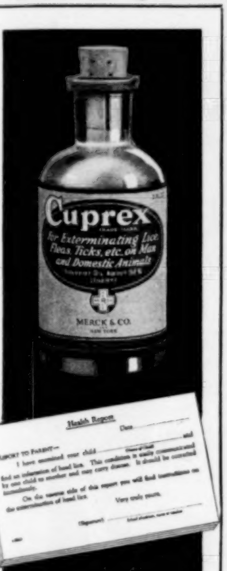
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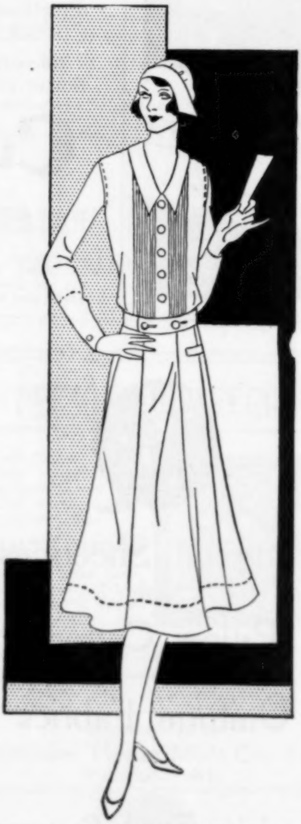

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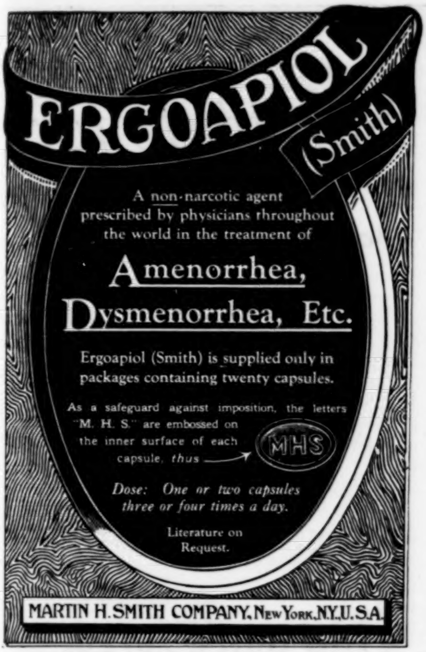

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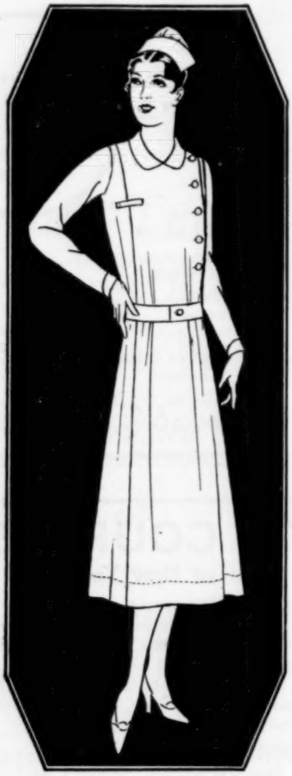

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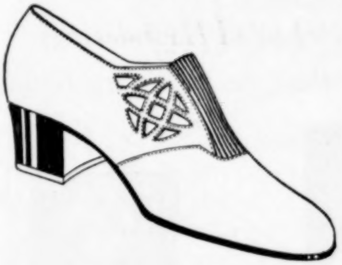

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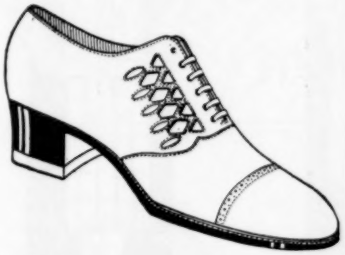

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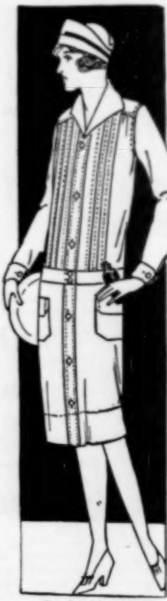

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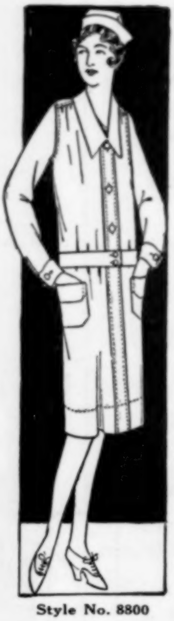

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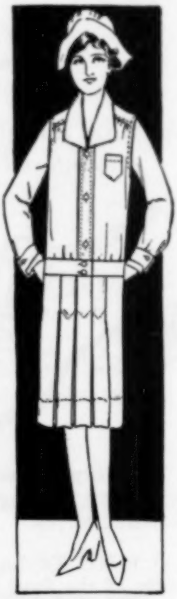

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